

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13817						13792					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY			Cecil			a. STATE			Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Port Deposit, Rural			b. COUNTY			Cecil		
c. LENGTH OF STAY IN 1b			Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Port Deposit, Rural		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Rock Run						Rock Run					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First		Middle		Last		Month		Day		Year	
Andrew		Robert		Bannon		Dec.		12,		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birth day)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 21, 1903		58 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		
Rigger						Army Chemical Center.			Cecil Co., Md. U S A		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Andrew J. Bannon						Dollie E. Wills					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT Address		
No						216-09-3797			Mabel O. Bannon, Port Deposit, Md. Rural		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>											
422.1 DUE TO <u>Arterio Sclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Chr. Myocarditis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June - 54 Dec. 12, 1961, that (I) (we) last saw the deceased alive on Dec. 12, 1961, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			22b. DATE SIGNED		
Clarence I. Benson M.D.						Port Deposit, Md.			Dec-13-61		
23a. BURIAL, CREMATION, or other disposition (If other, specify)						23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY		
Burial						12-15-1961			West Nottingham Cem.		
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25e. REC'D BY REGISTRAR		
<u>Lee A. Patterson</u>						Perryville, Md.			DEC 18 '61		
25b. REGISTRAR'S SIGNATURE						25d. LOCATION (City, town or county)			(State)		
<u>Clarence I. Benson</u>						Colora, Md. Rural					

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9217-90-3X

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.
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VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13793									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.3.			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Frances Middle Gail Last Bonham					4. DATE OF DEATH Month 12 Day 23 Year 19 61				
5. SEX F		6. COLOR OR RACE W		7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-1955		9. AGE (In years last birthday) 6 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James R. Bonham					14. MOTHER'S MAIDEN NAME Fanny L. Strope				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. _____				
17. INFORMANT James R. Bonham, Elkton R.D.3. Md.					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of both Femurs and fracture at base of skull DUE TO 5. min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by car as she ran across the road 20c. TIME OF INJURY Month, Day, Year 2.45 12 23 61 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road 20f. (City or town) Elkton (County) Cecil (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE R. C. Dodson M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) R. C. Dodson					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 12-27-61				
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME					24a. REC'D BY REGISTRAR DEC 27 '61				
24b. REGISTRAR'S SIGNATURE Charles L. Kraus					25. LOCATION (City, town, or country) North East, Md.				

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI
FROM : SAC, ELIZON, N.H. (100-111111)
SUBJECT: [REDACTED]
RE: [REDACTED]
DATE: 11-22-1955
12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13819

13794

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen	
c. LENGTH OF STAY IN IB 3 days		d. STREET ADDRESS 6 Taft	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT (NMI) BRAUN		4. DATE OF DEATH December 20 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-80
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not available		14. MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes S.A.W.		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (Name of hospital) attended the deceased from 12-17 1961 to 12-20 1961 and that death occurred at 8:45pm from the causes and on the date stated above.		22a. SIGNATURE S. Goldgraben M.D.	
22b. DATE SIGNED 12-21-61		22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN Chief, Medical Service VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12/22/1961	
23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13820

CERTIFICATE OF DEATH

13796

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 16 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 2254 Graythorn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HOWARD OLIVER BULETTE			4. DATE OF DEATH December 23 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1932		9. AGE (In years) IF UNDER 1 YEAR last birthday 29 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY Postal Service	11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Hugh Bulette			14. MOTHER'S MAIDEN NAME Florence Burkentine		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean		16. SOCIAL SECURITY NO. 213-26-1124	17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 592 X IMMEDIATE CAUSE (a) Uremia, severe DUE TO Chronic Glomulonephritis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH 4-6 weeks Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that IV (this hospital) attended the deceased from December 7, 1961 to December 23, 1961 that IV (we) last saw the deceased alive on Dec. 23rd, 19 61 and that death occurred at 7:15 PM from the causes and on the date stated above.					
22a. SIGNATURE A. L. Mooney			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-23-61
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. Asst. Clinical			22d. ADDRESS Pathologist, VAH., Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 27 1961	23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		23d. LOCATION (City, town or county) (State) HAYRE DE GRACE MD.
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell			25a. REC'D BY REGISTRAR DATE DEC 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 18797

13821

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RISING SUN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS PEARL STREET	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLE FREDRICK BURKINS, JR		4. DATE OF DEATH Month Day Year DECEMBER 5, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACETYLENE BURNER		10b. KIND OF BUSINESS OR INDUSTRY STEEL WORKS	
11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ALFRED BURKINS		14. MOTHER'S MAIDEN NAME LAURA M. SHADE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-61-8683	
17. INFORMANT MRS HAZEL BURKINS, RISING SUN, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Coronary insufficiency (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15 19 54 to 12/5 19 61 , that I last saw the deceased alive on 12/5 19 61 , and that death occurred at 9:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rising Sun, Md 12/7/61 ACTUAL SIGNATURE Neil Taylor M.D. PHYSICIAN'S NAME (Type) Neil Taylor, Jr. M.D. Rising Sun, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/1961	
22c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM		22d. LOCATION (City, town, or county) (State) COLORA MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md		24a. REC'D BY REGISTRAR DATE DEC 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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WILLIAM S. M. I.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13822

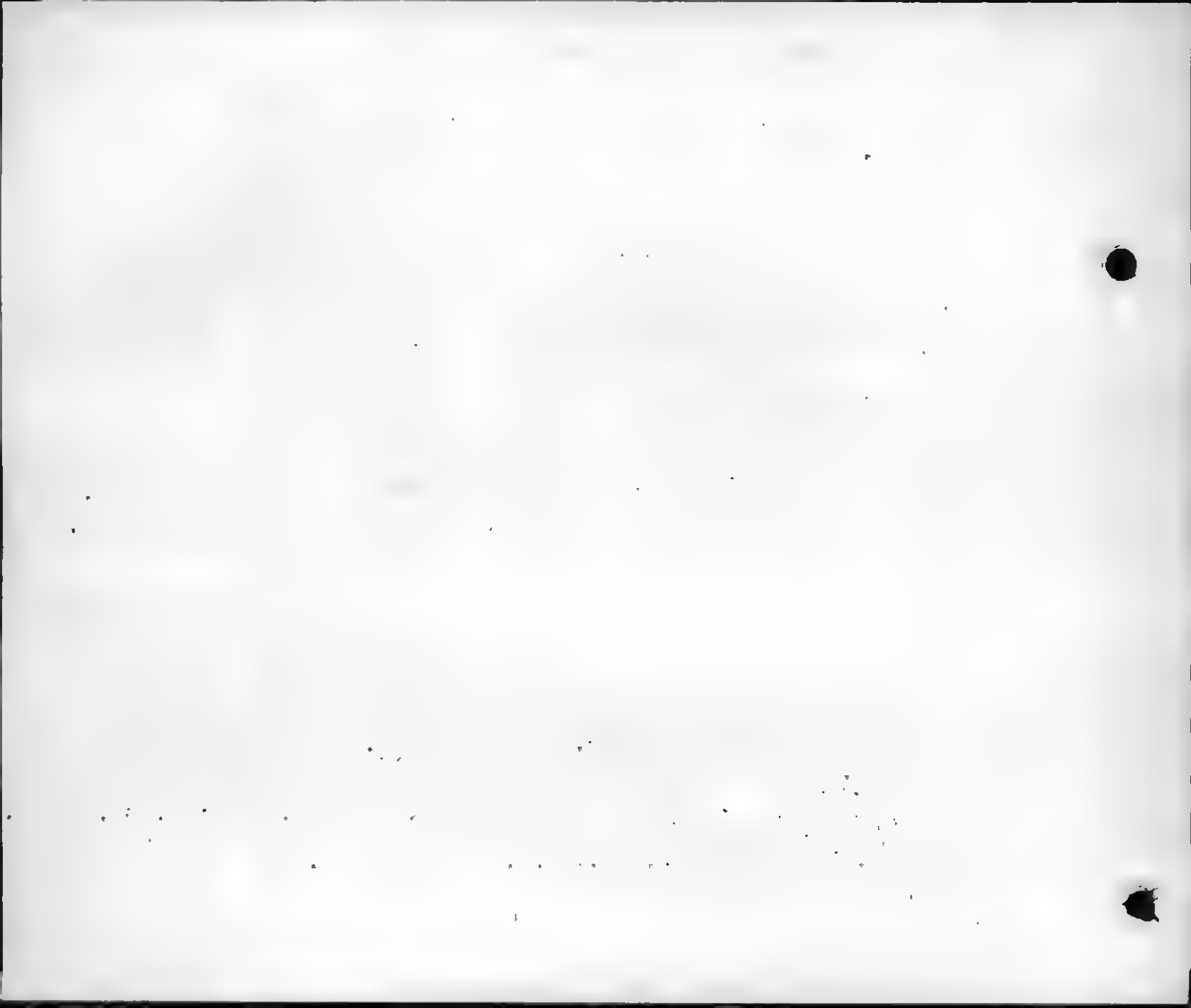
CERTIFICATE OF DEATH

Reg. Dist. No. 13798

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS Rd # 4,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Harry Last Carter		4. DATE OF DEATH Month 12 Day 25 Year 19 61	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29 1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonathan V. Carter		14. MOTHER'S MAIDEN NAME Mary R. Chaster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 215-30-1225	
17. INFORMANT ELVA Bostic		Address RD 3 Coatsville, Pa	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute coronary infarction DUE TO Coronary artery heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. several yrs. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15 , 19 61 to Dec. 25 , 19 61 , that I last saw the deceased alive on Dec. 24 , 19 61 , and that death occurred at 10:15a , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main St., Elkton, Md. DATE SIGNED 12/25/61 ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. 12/25/61 PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/61	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter de B... ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR JAN 2 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

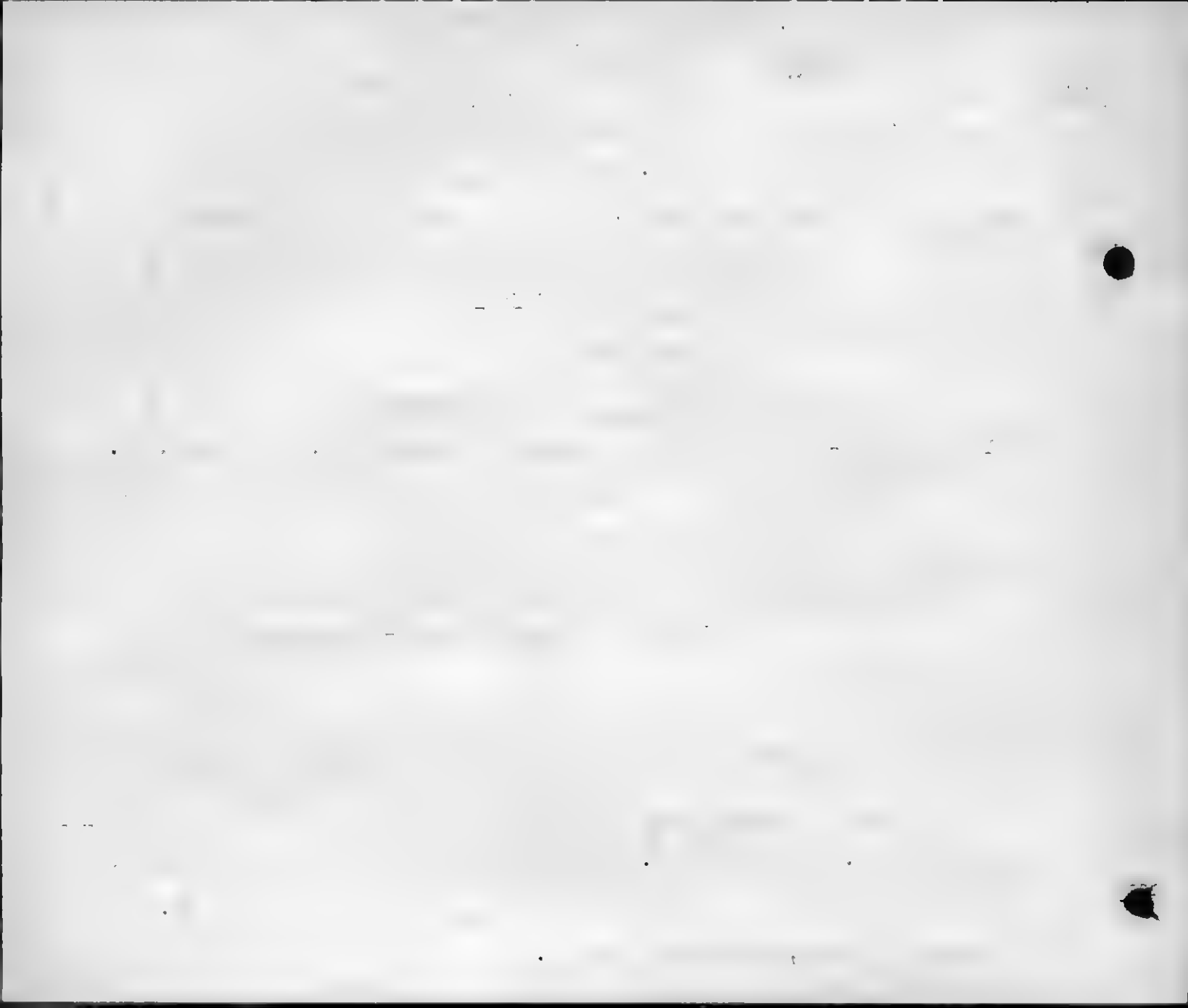
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be filed in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13823 CERTIFICATE OF DEATH 13799

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Hagerstown	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 631 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last GLENN HOWARD CORNELL		4. DATE OF DEATH December 3 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not available		10b. KIND OF BUSINESS OR INDUSTRY Not available	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Ralph Cornell		14. MOTHER'S MAIDEN NAME Ellie Spevil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-8 Bronchopneumonia left lung, severe DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized, - unknown		INTERVAL BETWEEN ONSET AND DEATH 10-14 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased attended the deceased from June 14, 1961 to December 3, 1961 and that death occurred at 3:15 p.m. from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 12-4-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) 12/7/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

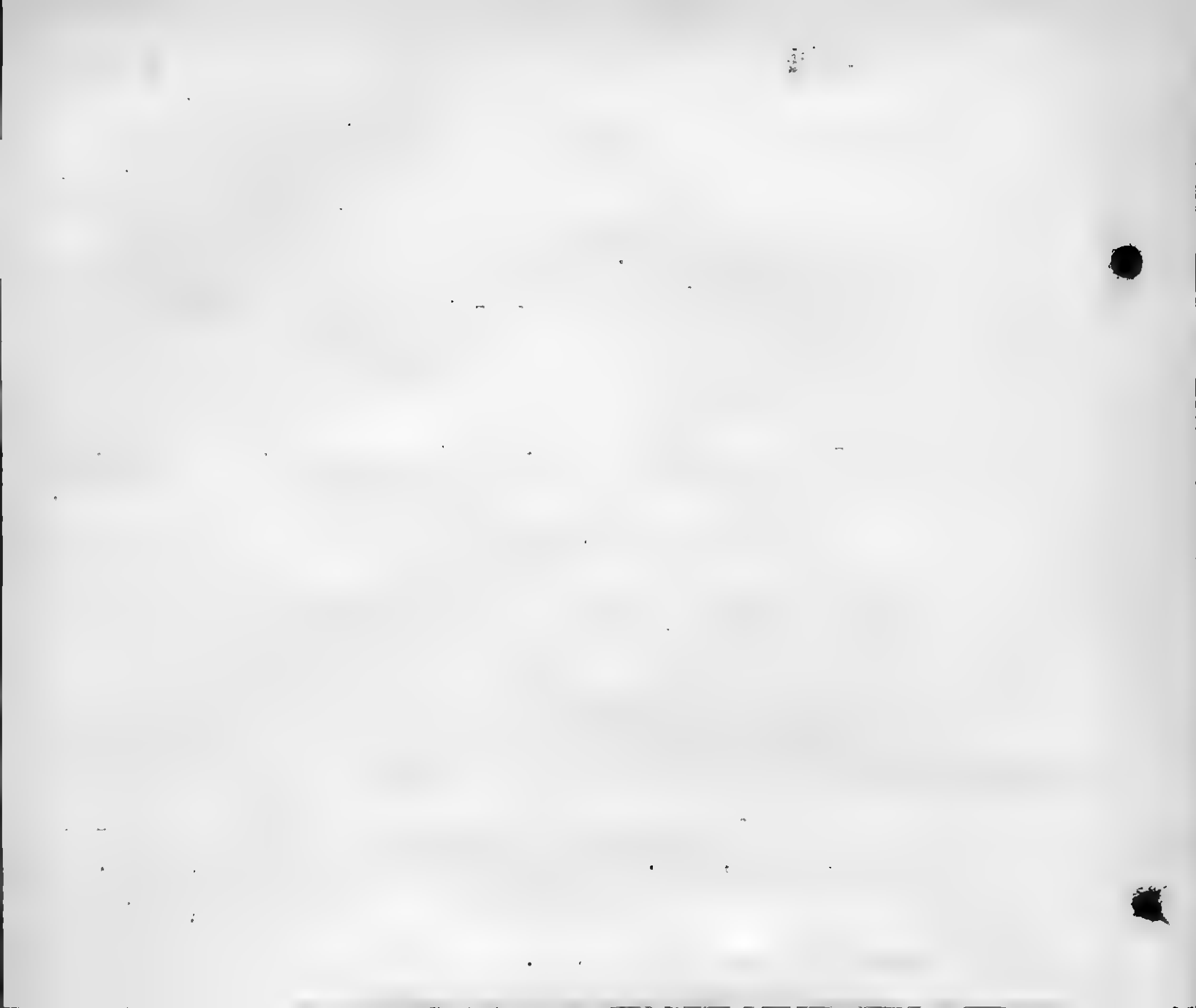


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13824 CERTIFICATE OF DEATH 13800

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN TB 10 days		d. STREET ADDRESS 3515 Meadowside Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLSWORTH G. CROPSLEY		4. DATE OF DEATH December 19 19 61	
5. SEX Male 16. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11-28-98		9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cropsey (deceased)		14. MOTHER'S MAIDEN NAME Lucy Hackley (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from December 9 19 61 to December 19 19 61 and that death occurred 9:05 AM on the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 12-20-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 12/21/1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE XXXXXXXXXX Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	



13825

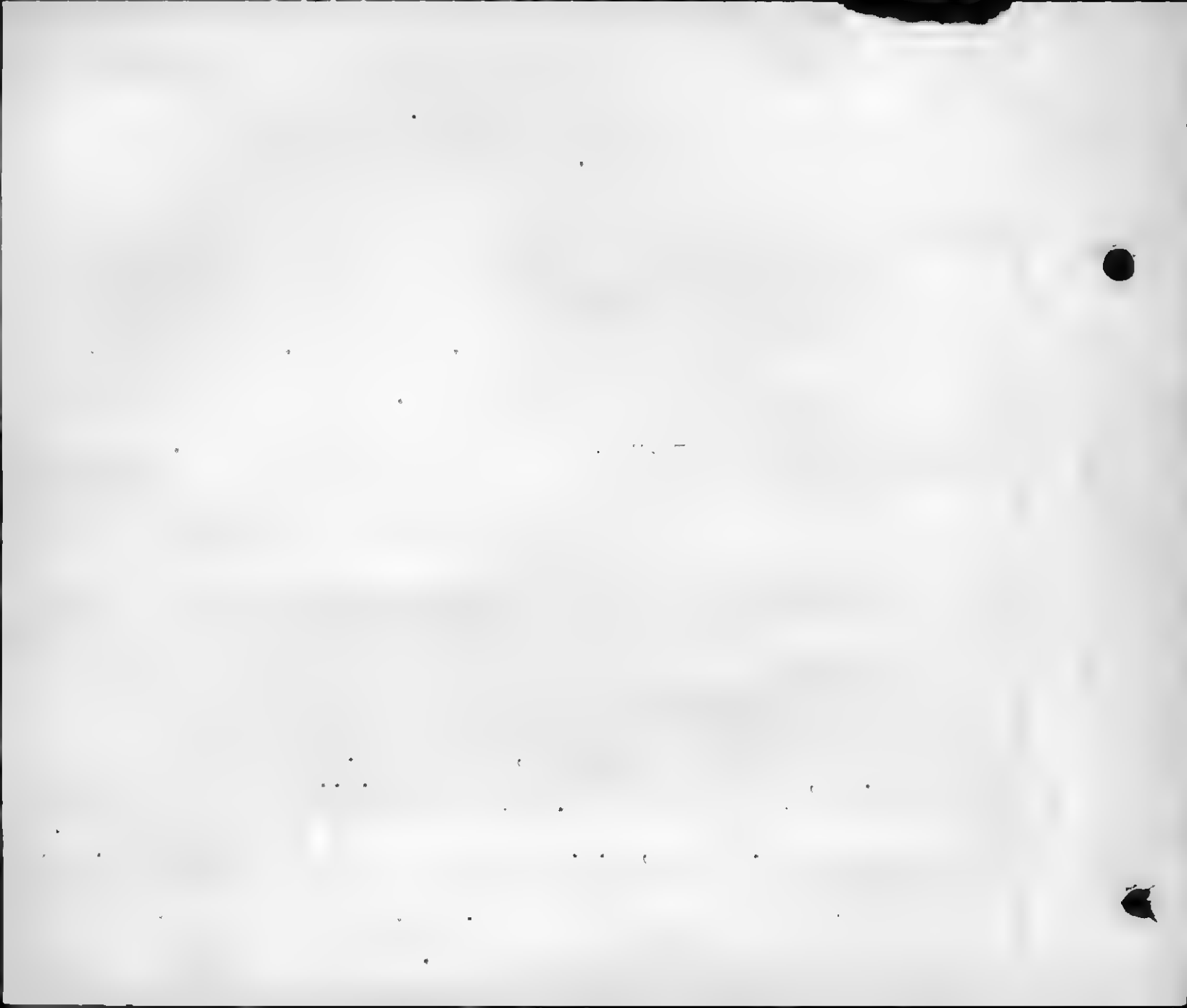
CERTIFICATE OF DEATH

Reg. Disk No. 13801

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elton	
c. LENGTH OF STAY IN 1b 4 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Washington Avenue		d. STREET ADDRESS 101 Washington Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Virginia DAVIS		4. DATE OF DEATH Month Day Year Dec. 29, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Nr. Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Beers		14. MOTHER'S MAIDEN NAME Sara E. Curry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-05-3877	
17. INFORMANT Margaret Bryson, Elton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic cardio-vascular disease 10 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11, 19 59, to Dec. 28, 19 61, that I last saw the deceased alive on Dec. 26, 19 61, and that death occurred at 3:45 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. Wright		DATE SIGNED Dec. 28, 1961	
PHYSICIAN'S NAME (Type) Samuel J. Wright, M.D.		ADDRESS (Street, city or town, state) 79 Amstel Avenue Newark, Del.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-61	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.		22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR Dec 2 '62	
ADDRESS 101 Washington Avenue, Elton, Md.		24b. REGISTRAR'S SIGNATURE William S. Howard	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. To be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13826

13802

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 30 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last An thony R Dvorak Jr.		4. DATE OF DEATH Month Day Year 12 15 1961					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 1-17-60	
9. AGE (in years last birthday) 1		IF UNDER 1 YEAR Months Days 28		IF UNDER 24 HRS. Hours Min. 00 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME An thony Dvorak				14. MOTHER'S MAIDEN NAME Ruth Di Ferassi m n de			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Anthony Dvorak Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 560.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Operation left Inguinal hernia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-15-61	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/61		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Hr. Elkton, Maryland		22d. LOCATION (City, town, or country) (State) Elkton, Md.	
23. FUNERAL DIRECTOR PUPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DEC 20 '61		24b. REGISTRAR'S SIGNATURE Clara S. Kraus			



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

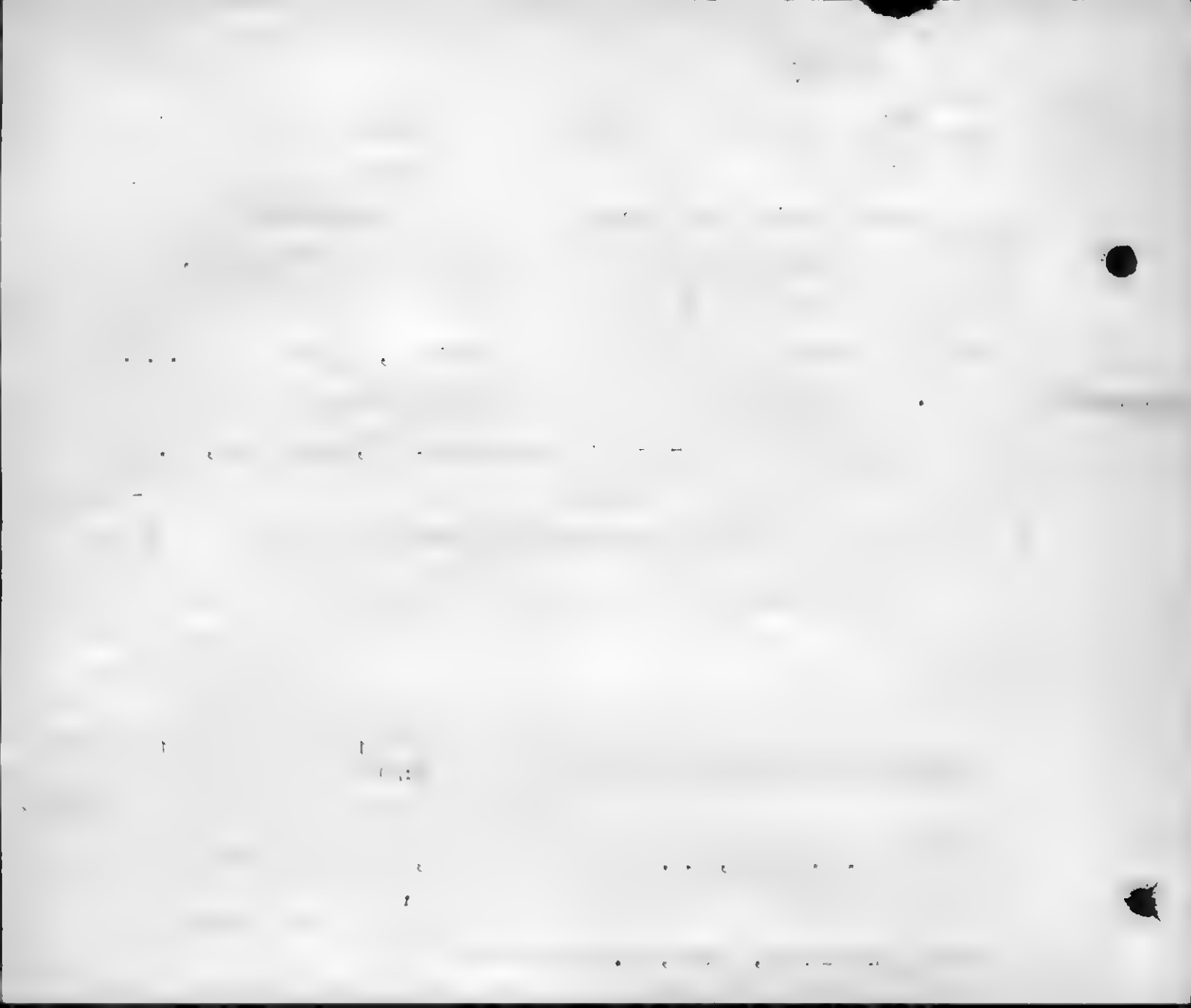
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13827

13803

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
c. LENGTH OF STAY IN 1b <u>28 Days</u>		d. STREET ADDRESS <u>110 Bridge Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>LEROY</u> Last <u>EDER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/6/92</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Custodian</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Fred W. Eder (Deceased)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		14. MOTHER'S MAIDEN NAME <u>Mary Harrington (Deceased)</u>	
16. SOCIAL SECURITY NO. <u>219-03-3611</u>		17. INFORMANT <u>VA Records, VAH, Perry Point, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF TONGUE WITH METASTASIS TO LIVER</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-10 Days</u> <u>7 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>11/26/</u> , 19 <u>61</u> to <u>12/24/</u> , 19 <u>61</u> , that <u> </u> and that death occurred at <u>5:40 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. L. Mooney, M.D.</u>		22b. ADDRESS <u>VAH, Perry Point, Maryland</u>	
22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED <u>12/24/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-28-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception Com.</u>		23d. LOCATION (City, town or county) (State) <u>Elkton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pippins Funeral Home, Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>DEC 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S SIGNATURE	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and is fully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

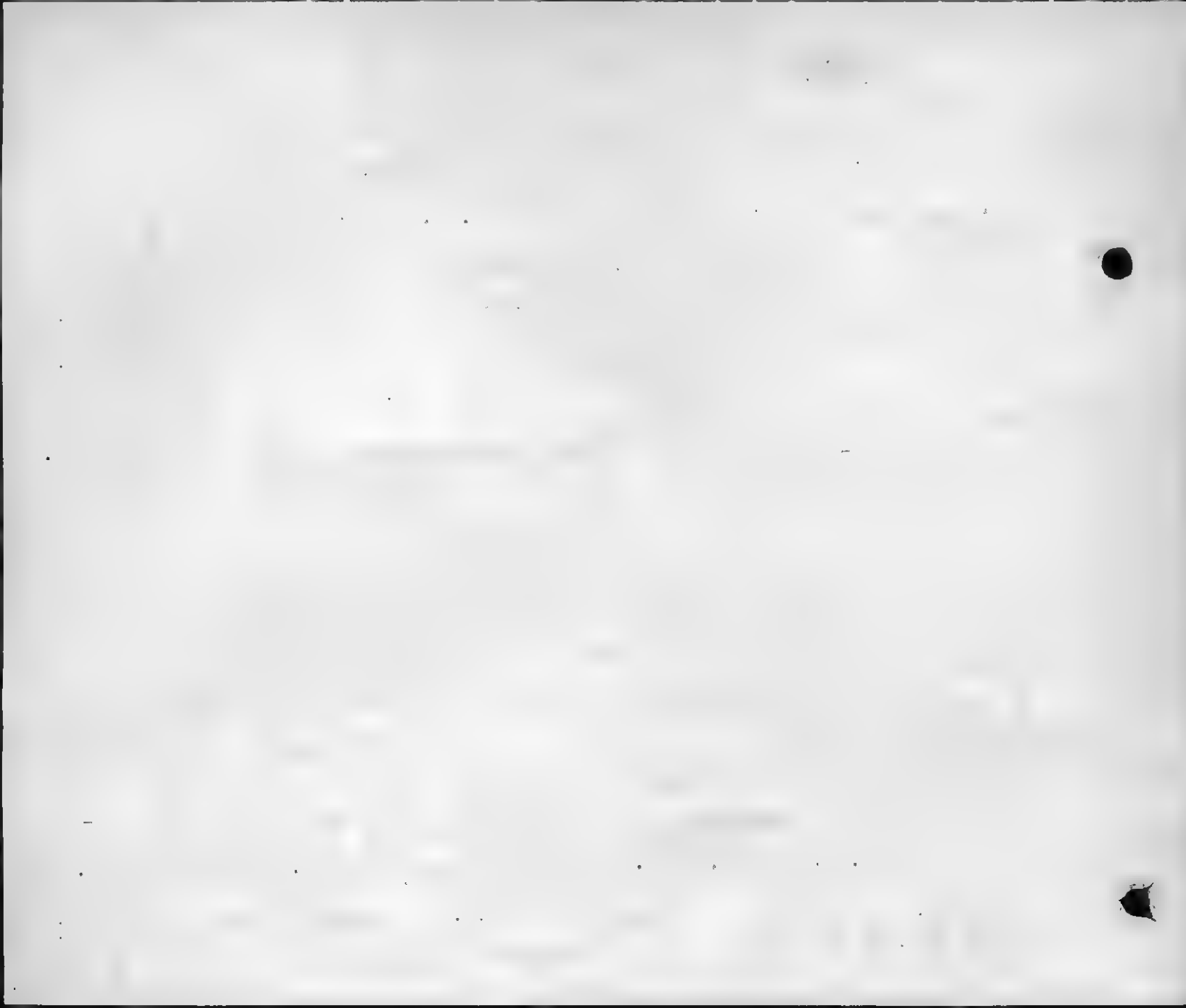
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13828

13804

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS Rt. 2, Box 24	
3. NAME OF DECEASED (Type or print) ADOLPH S. ELASEWITCH 5 SEX Male 6 COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (retired) 13. FATHER'S NAME Adam Elasewitch (deceased) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 220-03-0299 17. INFORMANT Not available		4. DATE OF DEATH December 7, 1961 9. AGE (In years last birthday) 65 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA 14. MOTHER'S MAIDEN NAME Margaret Seibert (deceased) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Ventricular arrhythmia 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease severe with myocardial fibrosis and mural thrombosis (c) Arteriosclerosis generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) unknown 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that XXXXXX attended the deceased from November 29, 1961, to December 7, 1961, and that death occurred at M. 8:30am from the causes and on the date stated above 22a. SIGNATURE A. L. MOONEY 22b. DATE SIGNED 12-7-61 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md. 22d. ADDRESS 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal 23b. DATE THEREOF Dec. 8, 1961 23c. NAME OF CEMETERY OR CREMATORY Lindsey & Sons, F.H., 23d. LOCATION (City, town or county) (State) Harrisonburg Va., 23e. ADDRESS Abingdon, Md., 23f. DATE DEC 11 '61 23g. REGISTRAR'S SIGNATURE Arthur S. Kline			



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13829

CERTIFICATE OF DEATH

13805

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
c. LENGTH OF STAY (in 1b) 18 MONTHS		d. STREET ADDRESS Queen St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Fowler		4. DATE OF DEATH Month Day Year 12/2/61 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1874
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer at Lumber yard		11. BIRTHPLACE (Country & State, or foreign country) Kent Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Fowler		14. MOTHER'S MAIDEN NAME Emma Ford DeFord	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-05-5017	
17. INFORMANT Address Clarence Fowler - Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 mos. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to Dec 2, 1961, that (I) (we) last saw the deceased alive on Dec 2, 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 2 Dec 61	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain		22d. ADDRESS Cecil, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF L2/5/61	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DEC 5 '61	
25b. REGISTRAR'S SIGNATURE C. L. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

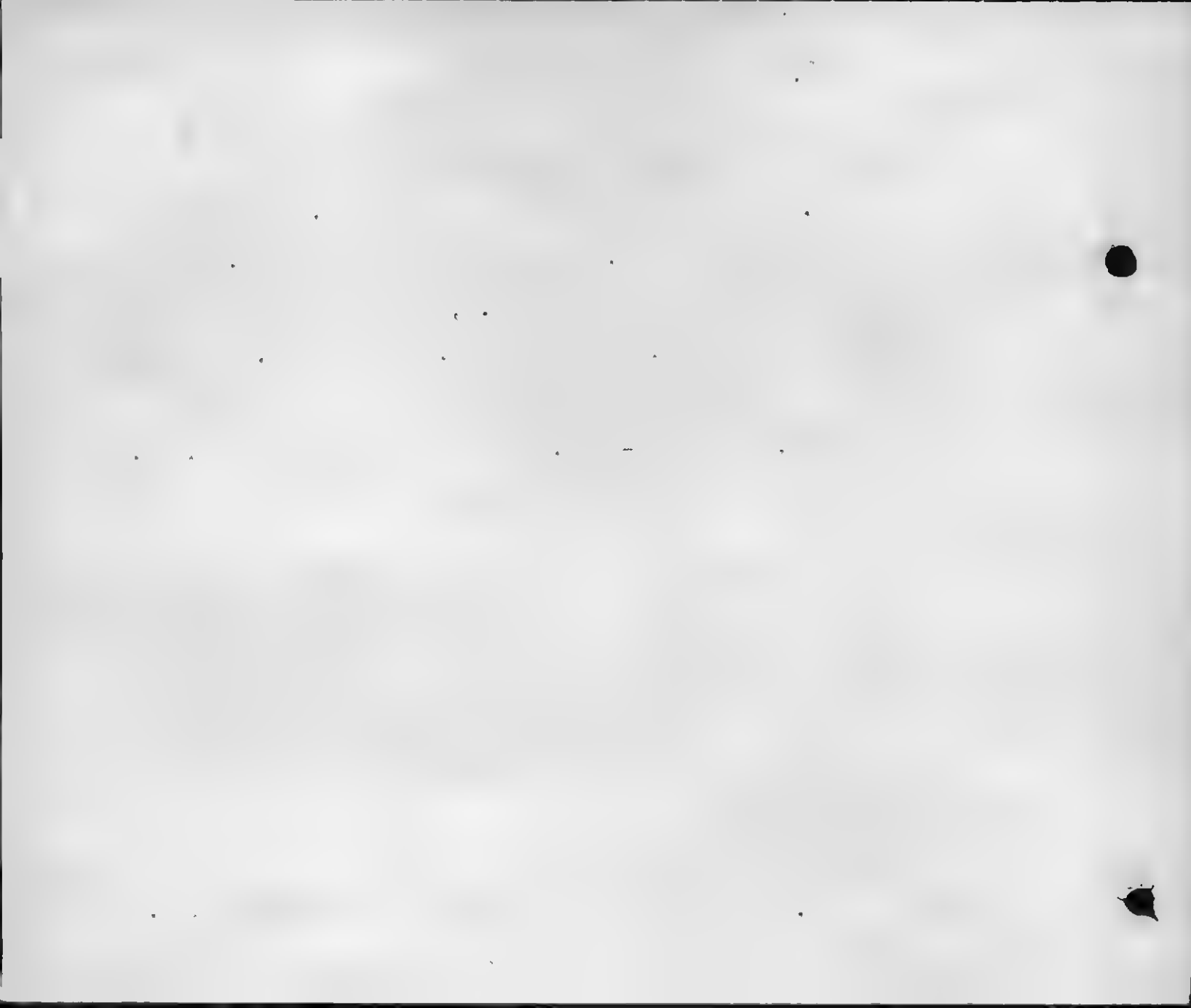
CERTIFICATE OF DEATH

13830

13806

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville c. LENGTH OF STAY IN 1b 30 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Front St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville d. STREET ADDRESS Front St.																			
3. NAME OF DECEASED (Type or print) Claude S. Hackler		4. DATE OF DEATH Month Dec. Day 15 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1909		9. AGE (In years last birthday) 52 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																					
Months	Days	Hours	Min.																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Dispatcher. U S V Hospital.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Va. U S A		12. CITIZEN OF WHAT COUNTRY?													
13. FATHER'S NAME Bruce Hackler				14. MOTHER'S MAIDEN NAME Cynthia Hash				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World W. 2				16. SOCIAL SECURITY NO 721-18-0031		17. INFORMANT Ruth Stowell, North East, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td colspan="4"> PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. </td> <td colspan="4"> (b) Cerebral hemorrhage (intracranial) Cerebral embolism Coronary thrombosis (myocarditis) </td> <td colspan="4"> (c) INTERVAL BETWEEN ONSET AND DEATH 5 minutes 30 minutes 1 hour </td> </tr> </table>												PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				(b) Cerebral hemorrhage (intracranial) Cerebral embolism Coronary thrombosis (myocarditis)				(c) INTERVAL BETWEEN ONSET AND DEATH 5 minutes 30 minutes 1 hour			
PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				(b) Cerebral hemorrhage (intracranial) Cerebral embolism Coronary thrombosis (myocarditis)				(c) INTERVAL BETWEEN ONSET AND DEATH 5 minutes 30 minutes 1 hour															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)											
21. I certify that (I) (this hospital) attended the deceased from June 1945 to December 1961, that (I) (we) last saw the deceased alive on December 14, 1961, and that death occurred at 3A, from the causes and on the date stated above.																							
22a. SIGNATURE Frank Wolbert MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED December 18, 1961															
22c. PHYSICIAN'S NAME (Type) FRANK WOLBERT MD				22d. ADDRESS HAVE DE GRACE MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) Port Deposit, Md.		(State) Rural													
24. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son				ADDRESS Perryville, Md				25a. REC'D BY REGISTRAR DEC 18 '61		25b. REGISTRAR'S SIGNATURE William S. Kraus													

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13831

CERTIFICATE OF DEATH

Reg. Dist. No. 13807

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Viola Middle H Last Harrington		4. DATE OF DEATH Month Dec. Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1882
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Rising Sun, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert C. Harrington		14. MOTHER'S MAIDEN NAME Sarah Hoopes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Lupfer, Chesapeake City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic hepatitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1961, to Dec 10, 1961, that I last saw the deceased alive on Dec 10, 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/20/61 ACTUAL SIGNATURE Henry D. Davis M.D. PHYSICIAN'S NAME (Type) HENRY U. DAVIS M.D. CHESAPEAKE CITY MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-23-61	22c. NAME OF CEMETERY OR CREMATORY West Nottingham	22d. LOCATION (City, town, or county) (State) Rising Sun B.D. Cecil, Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE DEC 27 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13832

CERTIFICATE OF DEATH

13808

1. PLACE OF DEATH

a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Perry Point, Md.

c. LENGTH OF STAY IN

57 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

VA Hospital

3. NAME OF DECEASED (Type or print)

First
Avon

Middle
W.

Hess

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

1-4-93

9. AGE (In years last birthday)

69 1/2

IF UNDER 1 YEAR

Months 11 Days 17

IF UNDER 24 HRS

Hours 19 Min. 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (County & State, or foreign country)

Stewartstown, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abraham Lincoln Hess

14. MOTHER'S MAIDEN NAME

ANNIE Shue (First name not available)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

159-03-5812

17. INFORMANT

VA Hospital Records - VA Hospital Perry Point, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Bronchopneumonia

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year
VA 19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ~~the deceased~~ attended the deceased from Oct. 25, 1961 to Dec. 21, 1961, and that death occurred on Dec. 21, 1961, at 6:45 a.m., from the causes and on the date stated above.

22a. SIGNATURE

S. Gold

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED

12-21-61

22c. PHYSICIAN'S NAME (Type)

S. GOLD, Chief, Medical Service

VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12 23 61

23c. NAME OF CEMETERY OR CREMATORY

First Methodist Church Cemetery - Fawn Grove, Pa.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

OSBURN FUNERAL HOME - Stewartstown, Pa.

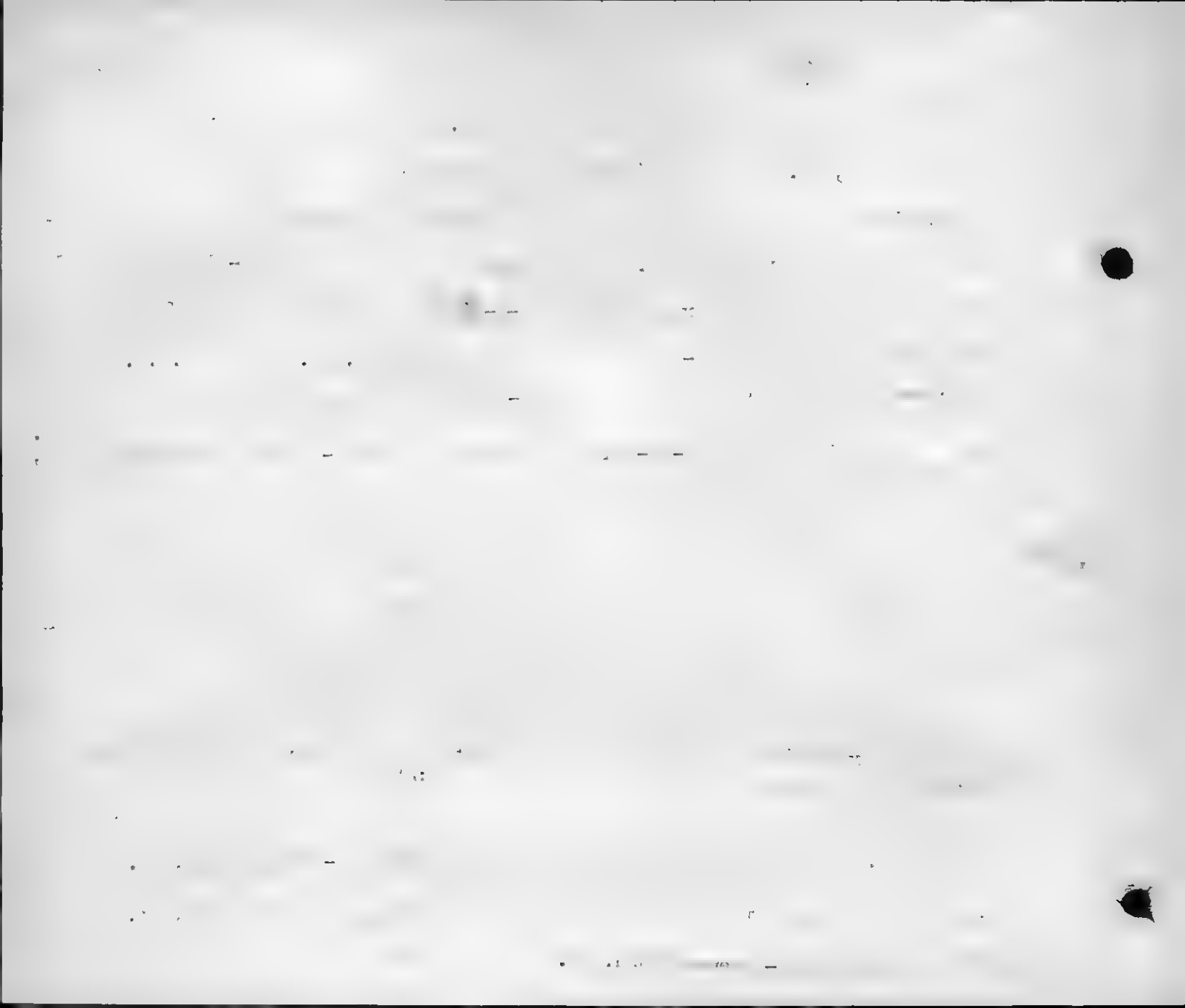
25a. REC'D BY REGISTRAR

DATE DEC 26 '61

25b. REGISTRAR'S SIGNATURE

William S. Thomas

OSTEAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and the attending physician and the funeral director, after this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

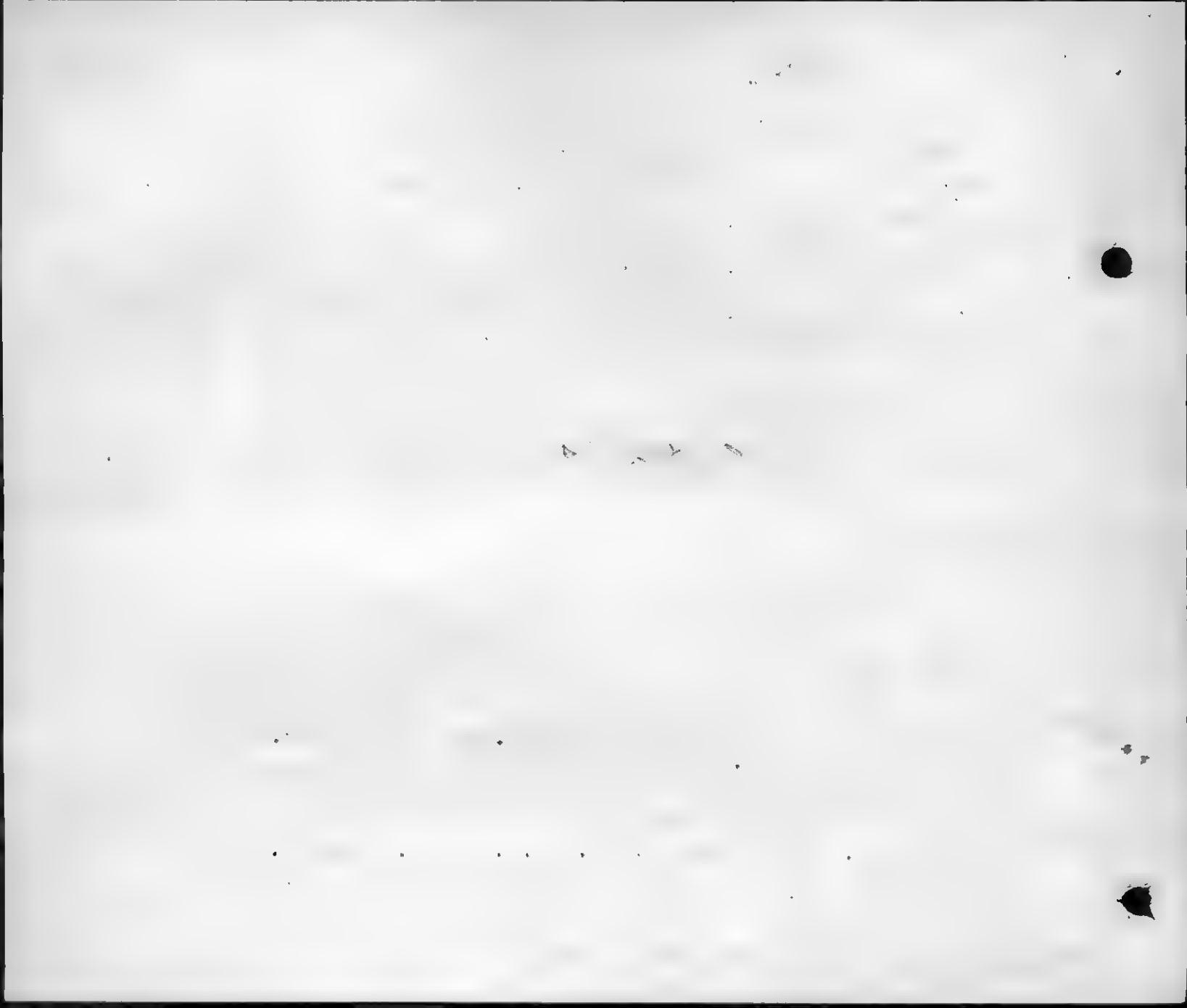
13833

CERTIFICATE OF DEATH

Item 8 Film G303 12/27/61 mb

13809

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elk Mills,</u> d. STREET ADDRESS <u>Rd # 4,</u>		3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>A.</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1961</u>											
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/24/1964</u> 19 <u>64</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. AGE (In years last birthday) <u>73</u> yrs.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Aument</u>		14. MOTHER'S MAIDEN NAME <u>Ella Forbert</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Walter Jackson</u>		17. INFORMANT <u>Elk Mills, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> Conditions, if any, which gave rise to immediate cause (b) <u>153.2</u> (a), stating the underlying cause last. (c) <u>over 4 months</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u>6:06p</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Aug. 29</u> (County) <u>61</u> (State) <u>Dec. 13</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13</u> to <u>Dec. 13</u> , that (I) (we) last saw the deceased alive on <u>Dec. 13</u> , and that death occurred at <u>6:06p</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>S. Ralph Andrews, Jr.</u>		22b. DATE <u>12/13/61</u>		22c. PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		22d. ADDRESS <u>233 E. Main St., Elkton, Maryland</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>Cherry Hill</u>		22g. LOCATION (City, town or county) <u>Maryland</u>		22h. (State) <u>Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>12/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		23d. LOCATION (City, town or county) <u>Cherry Hill</u>		23e. (State) <u>Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Bon...</u>		24a. ADDRESS <u>Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



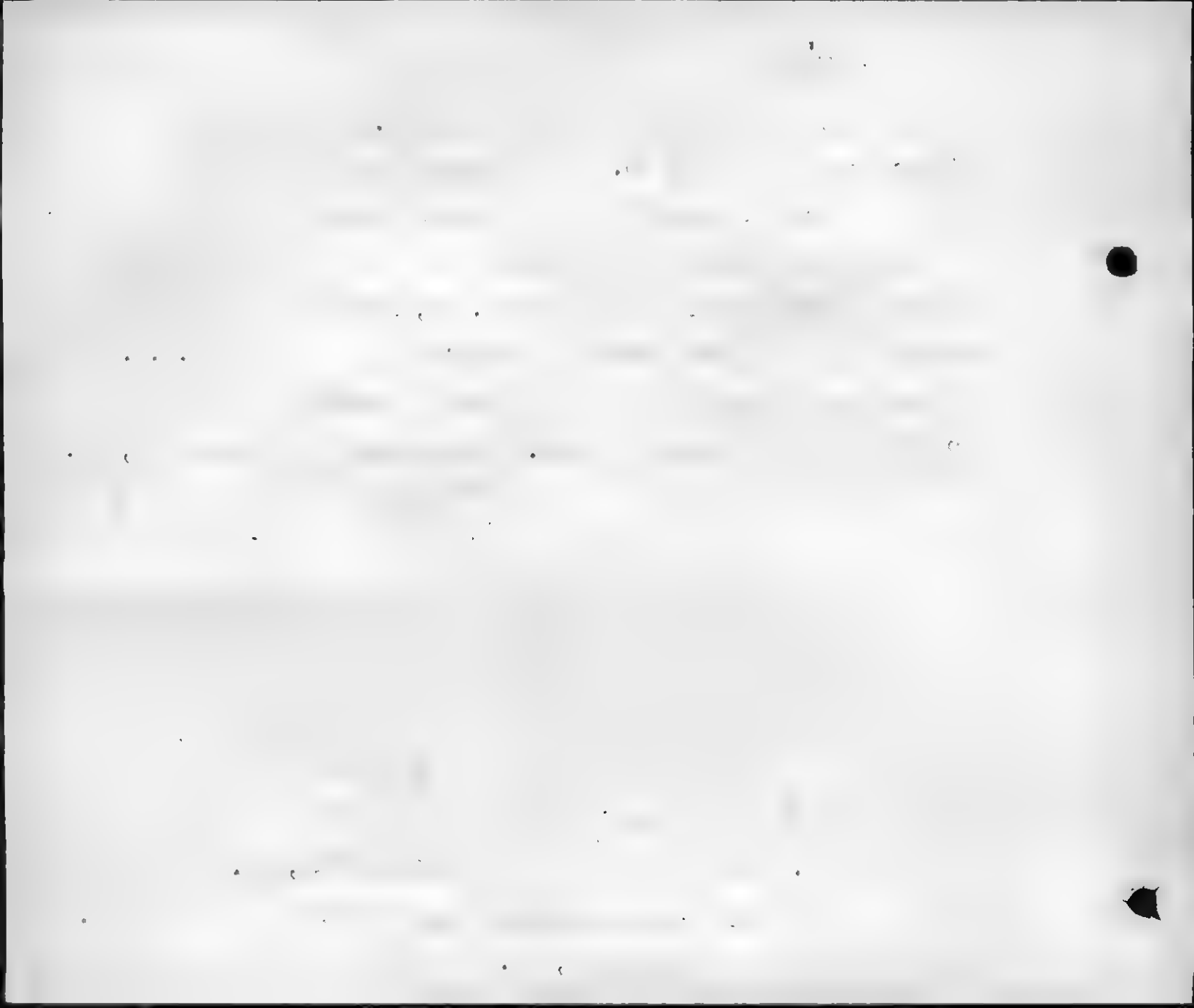
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13834

13810

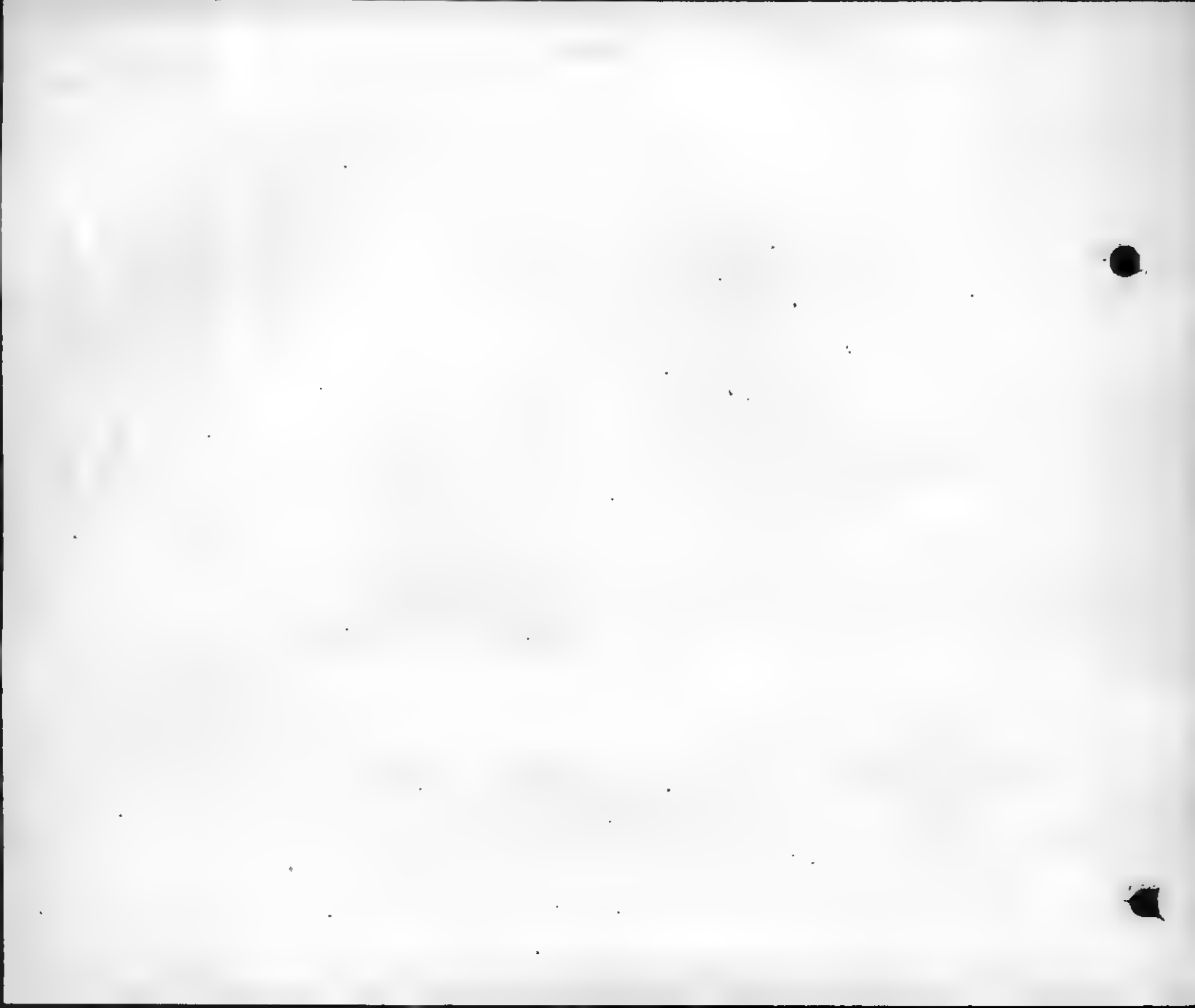
1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun			c. LENGTH OF STAY IN 1b 6 Mo.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peral Street				d. STREET ADDRESS Peral Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last Kennard				4. DATE OF DEATH Month 12/ Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1880		9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 3 Days 1 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allison Henry				14. MOTHER'S MAIDEN NAME Mary Burkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Joseph Pogue Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 wks 3 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 90 180 to 12/20 19 61 , that (I) (we) last saw the deceased alive on 12/19 19 61 , and that death occurred on 12/20 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE Neil R. Taylor Jr.				22b. DATE SIGNED DEC 27 '61		22c. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/1961		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem		23d. LOCATION (City, town, or county) (State) Colora Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lemon E. McMiller				25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE William L. Thomas	
26. ADDRESS Rising Sun, Md.							



CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 36 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				d. STREET ADDRESS 1 BOHEMIA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last Mary ELIZABETH Lee		4. DATE OF DEATH		Month Day Year Dec 10 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 17, 1893			
				9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Elkton Md		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME William Hughes				14. MOTHER'S MAIDEN NAME Anna Green					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		INFORMANT FRANK LEE		Address CHESAPEAKE CITY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Cerebellar Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO year. (c)								INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis, Coronary Artery Sclerosis, Huge ovarian Cyst								19. WAS ALTOGETHER PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1961, to 10 Dec 1961, that I last saw the deceased alive on 10 Dec 1961, and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wallace Obenshain M.D. 11 Dec 61 PHYSICIAN'S NAME (Type) Wallace Obenshain Cecilton, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 14, 1961		22c. NAME OF CEMETERY OR CREMATORY ELLINGTON CEMETERY		22d. LOCATION (City, town, or county) (State) ELKTON MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P.P. PIN FUNERAL HOME, Sandston, Md.				24a. REC'D BY REGISTRAR OAT DEC 14 '61		24b. REGISTRAR'S SIGNATURE			



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13836

13812

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia	
c. LENGTH OF STAY IN ID 8yrs. 9mo. 8days		d. STREET ADDRESS 4247 Penn Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last LEIPERT		4. DATE OF DEATH Month December Day 14 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-88
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Leipert		14. MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 168-16-6890	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericarditis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last (b) Uremia (c) Arterioneurophrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 15-20 days 15-20 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. (Name) attended the deceased from March 6, 1953, to December 14, 1961, and that death occurred at 4:55 PM from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE 12-14-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY		22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12/18/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Beverly National		23d. LOCATION (City, town or county) (State) Beverly, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE DEC 26 '61	
25b. REGISTRAR'S SIGNATURE C. L. S. Jones			



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13837 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13813											
1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Md. b. COUNTY Cecil							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. LENGTH OF STAY IN 1b 20 yrs.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles WESTON Loveless				4. DATE OF DEATH Dec. 20, 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1883		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boats				10b. KIND OF BUSINESS OR INDUSTRY General Laborer				11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Loveless				14. MOTHER'S MAIDEN NAME Rachel Horner				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 339-16-0574				17. INFORMANT Rachel Loveless, Chesapeake City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cronia Myocarditis Hypertension 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 Hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. C. DODSON				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-20-61			
EXAMINER'S NAME (Type) R. C. DODSON, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/23/61				22c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY			
22d. LOCATION (City, town, or country) RR. CHESTER, Md.				22e. (City, town, or country) (County) (State)							
23. FUNERAL DIRECTOR PIPON FUNERAL HOME				ADDRESS 1000 1/2 E. EIGHTH, Md.				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
				DATE DEC 22 '61							



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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

146-11
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13838 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if not in town; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Providence, Elkton, R.D.5.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) all life		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Pierce Taylor (MALIN) Malon		4. DATE OF DEATH Month Day Year 12 19 61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1913
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bennett Islen Malon Malon		14. MOTHER'S MAIDEN NAME Elizabeth Catherine Anderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 222-07-0963	
17. INFORMANT Mrs. Peirce Taylor Malon, Elkton, R.D.5. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Attached hose of tail pipe and inside of cab of truck	
20c. TIME OF INJURY Month, Day, Year 12-50 12/19/61		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Junk Yard Elkton R.D.5 Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 12-20-61	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/61	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cem.		22d. LOCATION (City, town, or country) (State) Cecil County, Md.	
23. FUNERAL DIRECTOR Ralph E. Hicks, Elkton, Md.		24a. REC'D BY REGISTRAR JAN 11 '62	
		24b. REGISTRAR'S SIGNATURE C. Henry L. Phipps	

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2. Содержание (содержит ли документ сведения, относящиеся к расследованию?)

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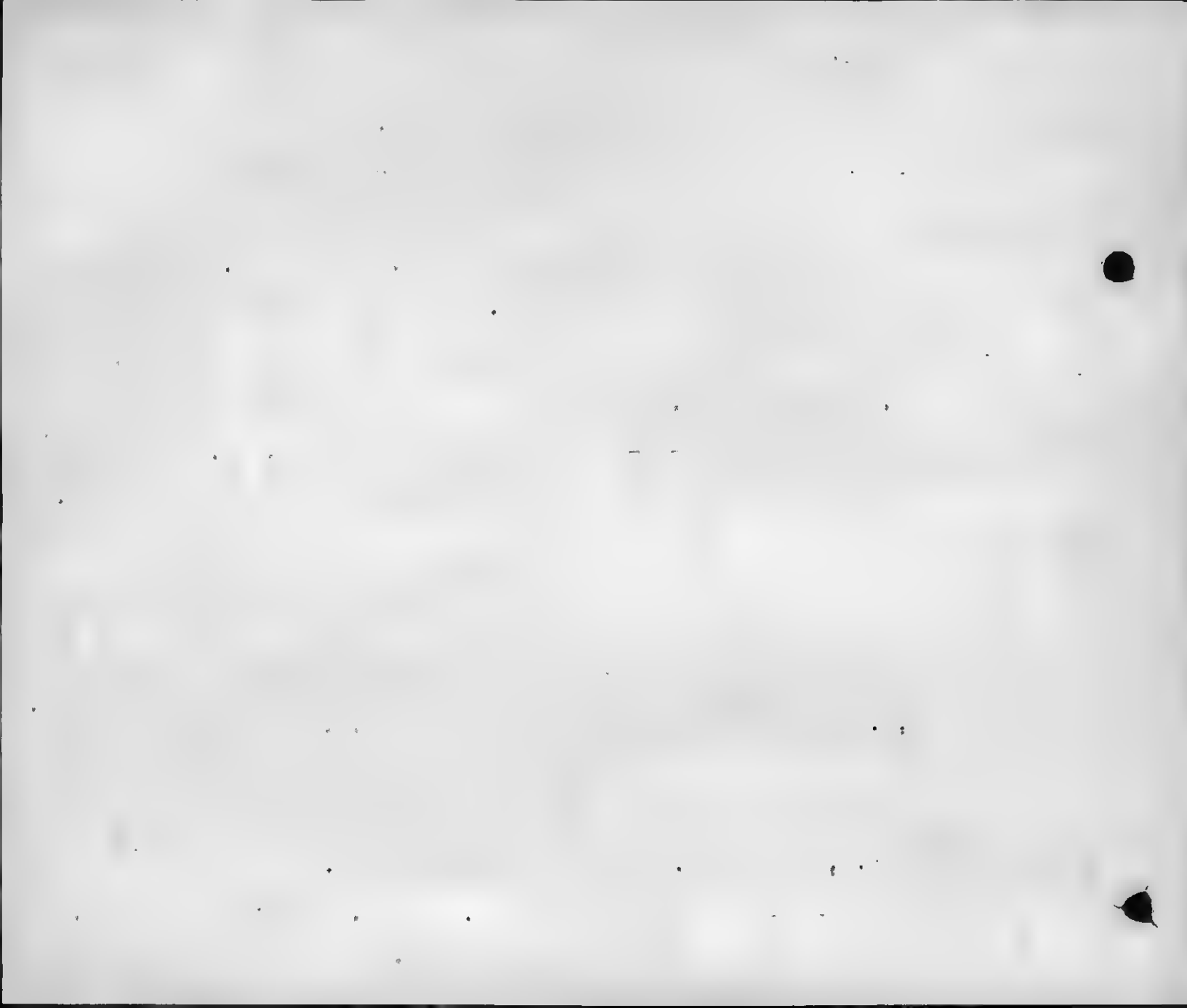
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FOR STATE
HEALTH DEPT.

any delay is necessary, the funeral director, Page 5, and the State Board of Health, File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 13839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13814 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Cecil | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Cecil | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton | | | | | | | |
| c. LENGTH OF STAY IN 1b 1 year | | | | d. STREET ADDRESS Browns Shore | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Maurice | | | | 4. DATE OF DEATH Dec. 19 19 61 | | | | 5. SEX Male | | | |
| 6. COLOR OR RACE White | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Oct. 17, 1914 | | | | 9. AGE (In years last birthday) 47 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maintenance | | | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Penna. | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Morris H. Matsinger, Sr. | | | | 14. MOTHER'S MAIDEN NAME Irene Kennedy | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no | | | | 16. SOCIAL SECURITY NO. 173-10-1560 | | | | 17. INFORMANT Lucille Matsinger, R. D. #1, Elkton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 22 Bullet in the forehead | | | | | | | | | | | |
| 976X DUE TO (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 22 caliber rifle | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 3:05 P.M. 12/19/61 | | | | | | | | | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence | | | | | | | | | | | |
| 20f. (City or town) R.D. #1, Elkton, Cecil, Md. | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| 23. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| 24. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| DATE SIGNED 12-20-61 | | | | | | | | | | | |
| 25. EXAMINER'S NAME (Type) R.C. DODSON, M.D. | | | | | | | | | | | |
| 26. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | | |
| 27. DATE THEREOF 12-22-61 | | | | | | | | | | | |
| 28. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk. | | | | | | | | | | | |
| 29. LOCATION (City, town, or country) Mr. Elkton, Md. | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR PIPPI FUNERAL HOME Donald M. Pipp | | | | | | | | | | | |
| 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| 24c. ADDRESS 24d. DATE 22 '61 | | | | | | | | | | | |



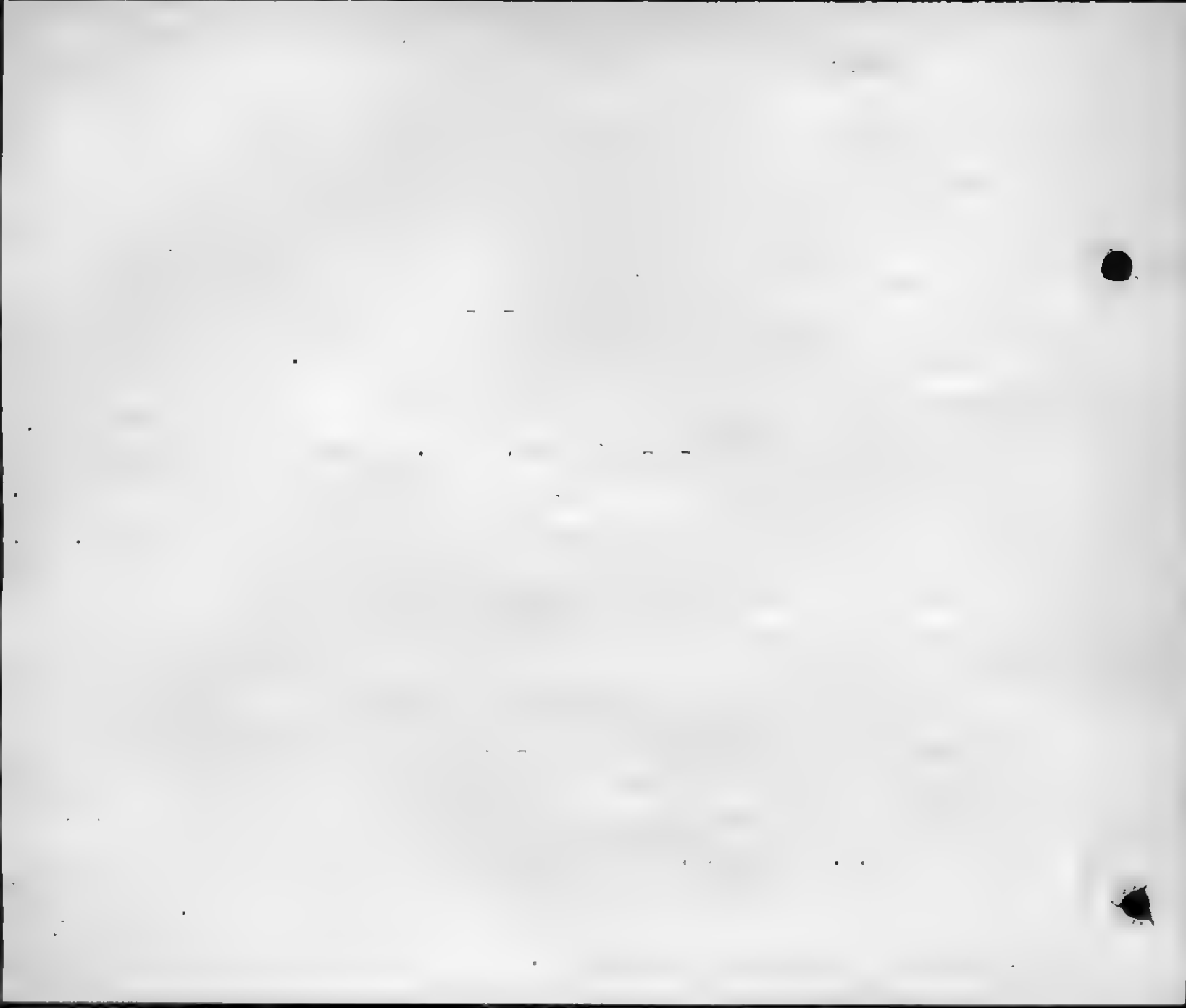
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13840 CERTIFICATE OF DEATH 13815

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN IL 6 mo. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. sent)
a. STATE Virginia | | b. COUNTY | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | 5303 Clifton Street | | 85x-3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOSEPH | | (N) one | | MOFFATT | | 4. DATE OF DEATH 12 18 1961 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-26-93 | | 9. AGE (In years last birthday) 68 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (County & State, or foreign country) New Castle, Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOSEPH MOFFATT | | 14. MOTHER'S MAIDEN NAME SARAH NIMMO | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1 | | 16. SOCIAL SECURITY NO. 577-24-6257 | | 17. INFORMANT Mrs. Ada E. Moffatt (Wife) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia, left lower lobe
DUE TO (b) Old Myocardial Infarction
DUE TO (c) Arteriosclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH 7 To 10 Dys.
Approx. 6 Mon. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year 19 12 15 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | | 20h. (City or town) (County) (State) | | 20i. (City or town) (County) (State) | | 20j. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from 6-15-61, to 12-18-61, and that death occurred at 2:PM, from the causes and on the date stated above. | | 22a. SIGNATURE A. L. Mooney | | 22b. DATE SIGNED 12-18-61 | | 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12/19/61 | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) Arlington, Va. | | 23e. (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md. | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE DEC 26 '61 | | 25d. (State) | |

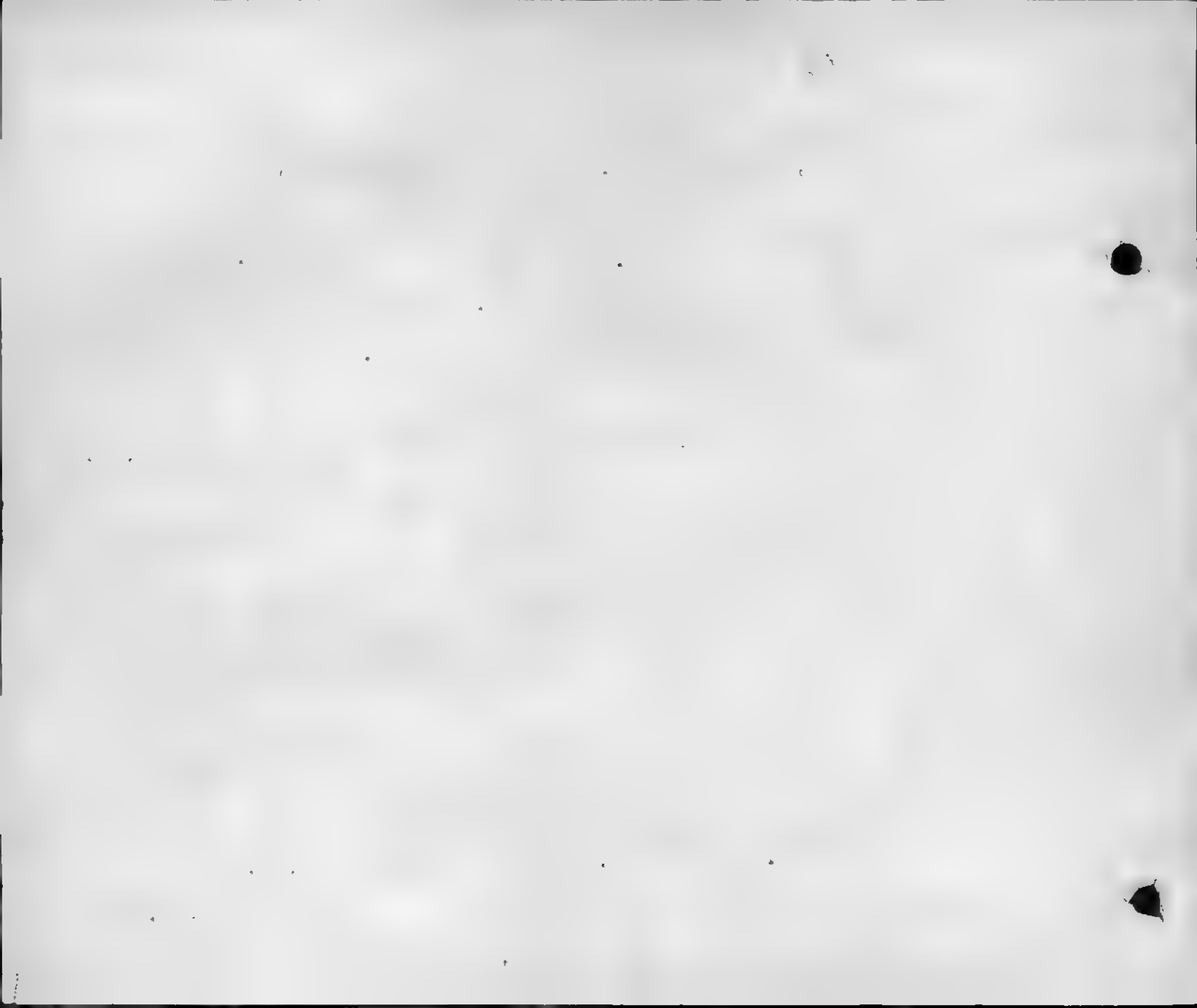


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13841
CERTIFICATE OF DEATH
13816

| | | | |
|--|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City, Rural
d. STREET ADDRESS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural | | c. LENGTH OF STAY IN 1b 3 Yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Samuel D. Moore | | 4. DATE OF DEATH Dec. 18 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 5, 1885 |
| 9. AGE (in years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY U S Government | |
| 11. 8TH PLACE (County & State, or foreign country) Cecil Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME John Moore | | 14. MOTHER'S MAIDEN NAME Sarah Ann Parks | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 169-20-1560 | |
| 17. INFORMANT Mrs Cyrus Burlin, Port Deposit, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT
442X DUE TO
Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE
(c) DISSEMINATED SCLEROSIS
INFLUENZA
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 166. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1961, to Dec 18, 1961, that (I) (we) last saw the deceased alive on 12-18-1961, and that death occurred at 8 PM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE G.H. Richards Jr. | | 22b. DATE SIGNED 12-19-61 | |
| 22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr. | | 22d. ADDRESS Port Deposit, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-21-1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery | | 23d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson | | 25a. REC'D BY REGISTRAR DEC 22 61
25b. REGISTRAR'S SIGNATURE | |

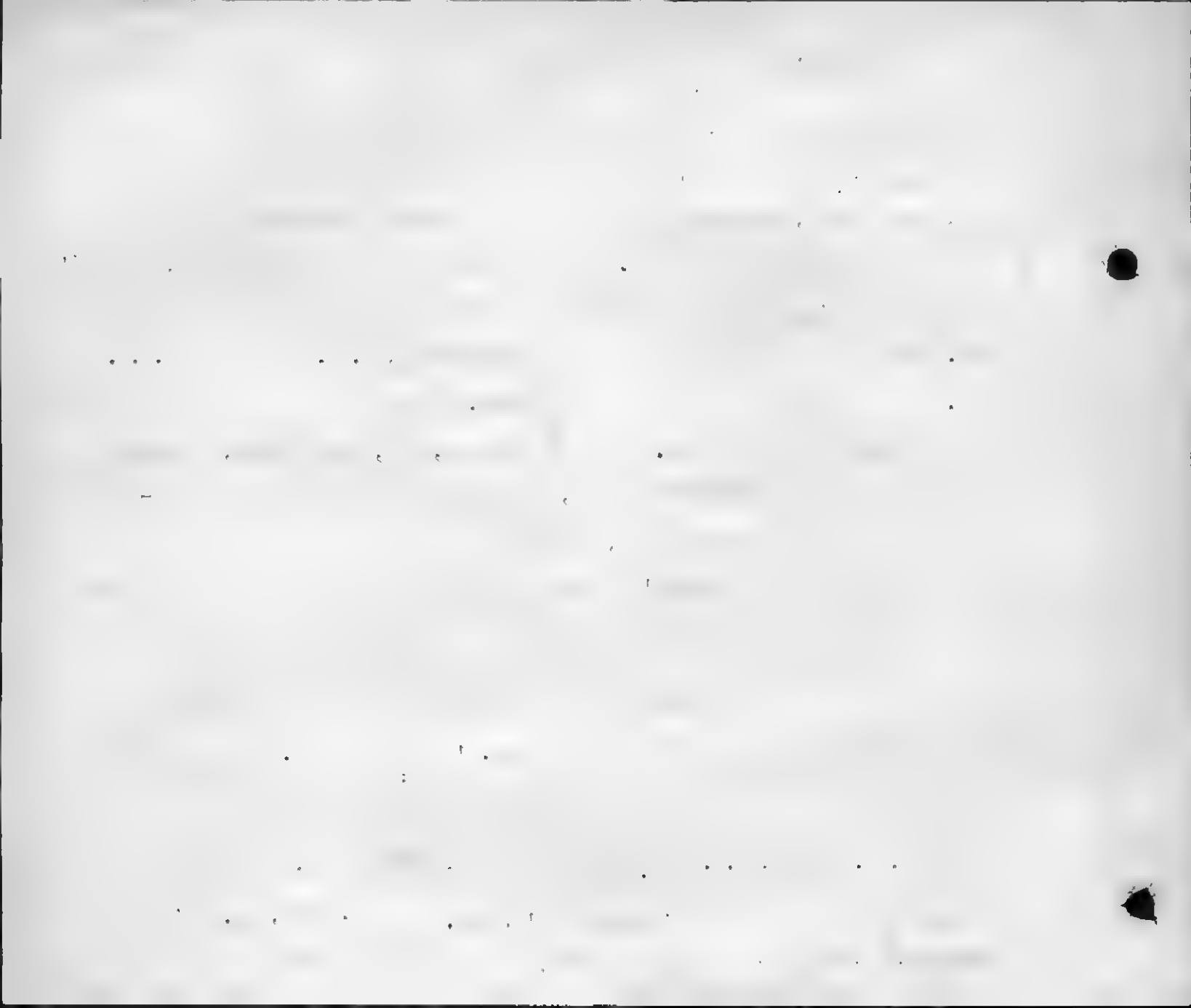


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13842 CERTIFICATE OF DEATH 13817

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived; if Institution: Residence before admission)
a. STATE Maryland b. COUNTY D | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Upper Marlboro | |
| c. LENGTH OF STAY IN TB
109 Days | | d. STREET ADDRESS
Post Office Box 245 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VAH, Perry Point, Maryland | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
HENRY C. PEITZ | | 4. DATE OF DEATH
December 19, 1961 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH
6/12/90 | | 9. AGE (In years, last birthday)
71 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Peitz | | 14. MOTHER'S MAIDEN NAME
Katie Hess | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WWI & II | | 16. SOCIAL SECURITY NO
Unk. | |
| 17. INFORMANT
VA Records, VAH, Perry Point, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL
350.0 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last }
(b) DEBILITATION, CHRONIC
(c) PARKINSON'S DISEASE
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Unknown | | INTERVAL BETWEEN ONSET AND DEATH
7-10 Days
Months
Unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that M. L. MOONEY attended the deceased from Sept. 1, 1961, to Dec. 19, 1961 , and that death occurred at 6:10 PM from the causes and on the date stated above. | | 22a. SIGNATURE
A. L. MOONEY, M.D. | |
| 22b. PHYSICIAN'S NAME (Type)
A. L. MOONEY, M.D. | | 22c. ADDRESS
VAH, Perry Point, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/21/1961 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL
Arlington Nat'l. Cem. | | 23d. LOCATION (City, town or county) (State)
Ft. Myer, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Pennington & Son, Havre de Grace, Md. | | 25a. REC'D BY REGISTRAR
DEC 26 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | 25c. DATE
12/20/61 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and carefully filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Known Locally as Bessie Garrison (Price)

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | |
|---|--|--|--|--|--|--|--|
| a. COUNTY | | | | a. STATE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | b. COUNTY | | | |
| c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| 5. SEX | | | | 6. COLOR OR RACE | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 8. DATE OF BIRTH | | | |
| 9. AGE (In years "IF UNDER 1 YEAR" "IF UNDER 24 HRS.") | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| 11. BIRTHPLACE (Country & State, or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. co.) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | Acute Coronary Occlusion | | | |
| 420.1 DUE TO | | | | Myocardial infarction, massive | | | |
| Conditions, if any, which gave rise to immediate cause (b) | | | | | | | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? | | | |
| Severe coronary sclerosis, severe congestive heart failure | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | | |
| Hour a.m. p.m. | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 8 1961 to 17 Dec 61, 1961, that (I) (we) last saw the deceased alive on 17 Dec 61, 1961, and that death occurred at 4:20 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE | | | | 22b. DATE SIGNED | | | |
| Wallace Obenshain | | | | 19 Dec 61 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| Wallace Obenshain, M.D. | | | | Cecilton, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF | | | |
| Burial | | | | Dec. 21, 1961 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town or county) (State) | | | |
| Cecilton Cemetery | | | | Cecilton Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | 25a. REC'D BY REGISTRAR | | | |
| Edward Bellows | | | | DATE DEC 26 '61 | | | |
| ADDRESS | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Cecilton Md. | | | | Cecilton Md. | | | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12011 CERTIFICATE OF DEATH

13844

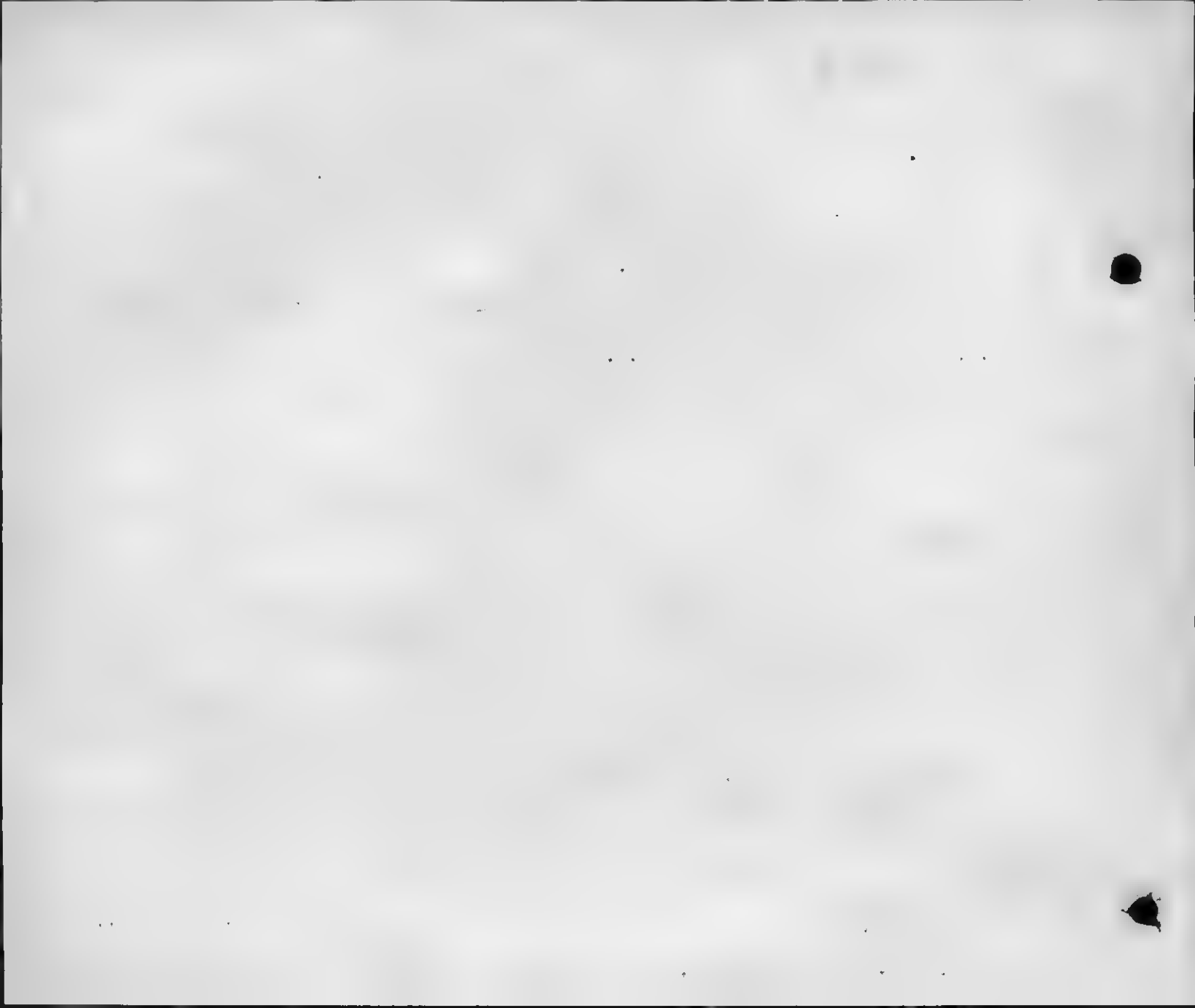
13819

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>Cecil</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>Cecil</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North East</u>
d. STREET ADDRESS
<u>North East</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North East</u> | | c. LENGTH OF STAY IN 1b
<u>42 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>CURTIS W. REED</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>25</u> Year <u>1961</u> | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>8-19-1874</u> | |
| 9. AGE (In years last birthday)
<u>87 yrs.</u> | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | |
| 11. IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>No information</u> | | 14. MOTHER'S MAIDEN NAME
<u>No information</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT
<u>Albert Reed North East, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u>
<u>150.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(c) <u> </u>
DUE TO
cause lost. <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
<u>Hypertrophic osteoarthritis, diabetes mellitus, prostatic hypertrophy</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u> </u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
<u> </u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u> </u>
<u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> <u> </u> <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan.</u> 19 <u>61</u> , to <u>25 Dec.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>24 Dec.</u> 19 <u>61</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Klaus H. Huebner</u> | | 22b. DATE SIGNED
<u>12/25/61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Klaus H. Huebner M.D.</u> | | 22d. ADDRESS
<u>North East, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12-28-1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Methodist</u> | | 23d. LOCATION (City, town or county) (State)
<u>North East, Cecil Co., Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph R. Grant</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 29 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | 25c. REGISTRAR'S SIGNATURE
<u> </u> | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/60



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

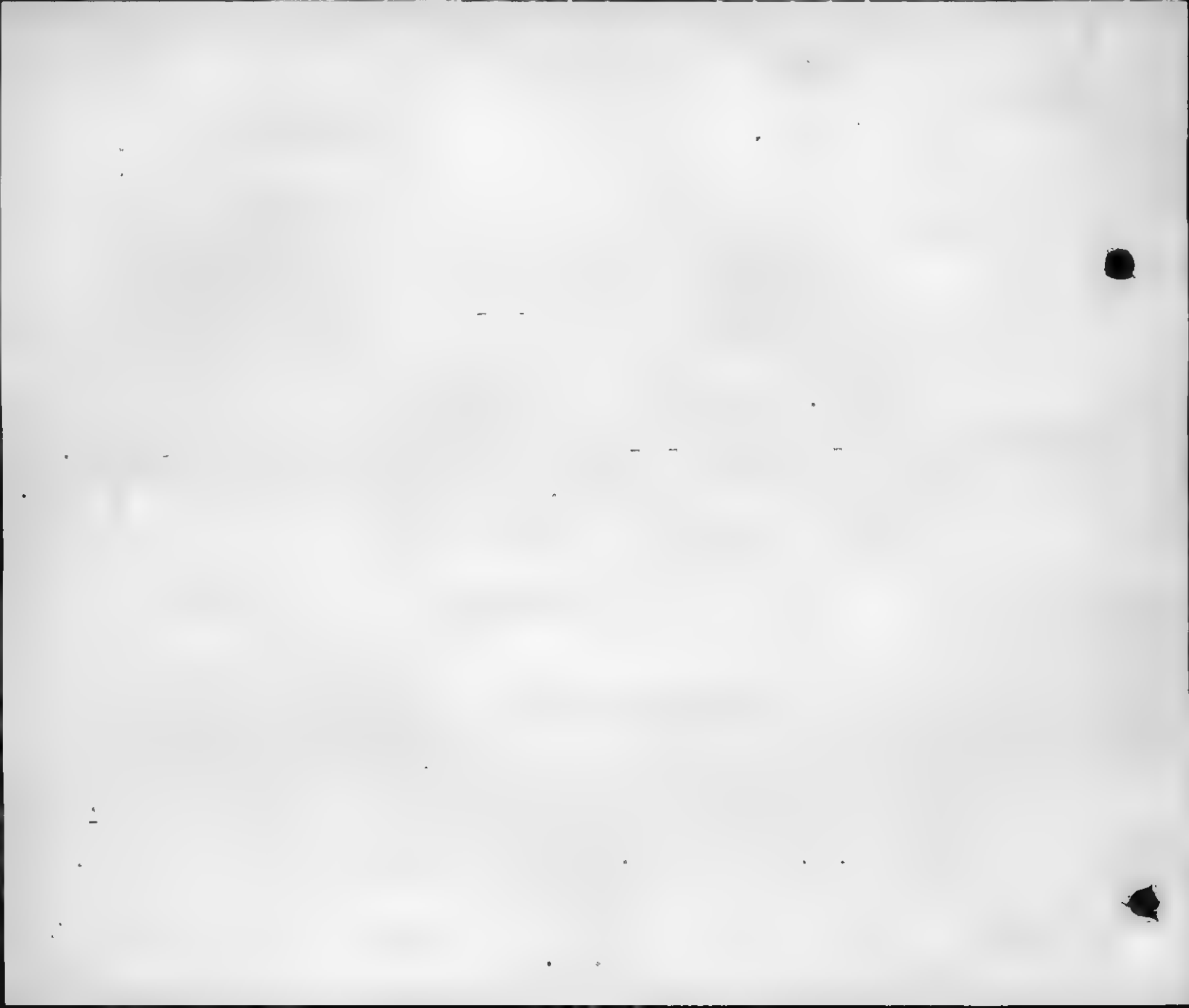
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13845

13820

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
CECIL | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PERRY POINT | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
116 N. Pine Street | |
| 3. NAME OF DECEASED
(Type or print)
First JOHN Middle H. Last RENNER | | 4. DATE OF DEATH
Month 12- Day 19 Year 19 61 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-20-93 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Houseman | | 10b. KIND OF BUSINESS OR INDUSTRY
Not available | 9. AGE (In years last birthday)
68 yrs |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
CHARLES RENNER | | 14. MOTHER'S MAIDEN NAME
GEORGIANA ANDERSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW-1 | | 16. SOCIAL SECURITY NO.
213-16-5877 | |
| 17. INFORMANT
Address
Hospital Records & Mother, Mrs. Georgian Renner, 3600 Fairview Ave., Balto., Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral
5 27 1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) Emphysema With Bronchiectasis
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
7 Days
1 Year | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that A. L. Mooney attended the deceased from 11-27-1960 to 12-19-1961 and that death occurred at 2:55 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. L. Mooney | | 22b. DATE SIGNED
12-20-61 | |
| 22c. PHYSICIAN'S NAME (Type)
A. L. MOONEY, ASST. Clinical | | 22d. ADDRESS
VA HOSPITAL, PERRY POINT, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 23b. DATE THEREOF
12/22/1961 | |
| 23c. NAME OF CEMETERY OR PLACE OF BURIAL
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Bennington & Son, Havre de Grace, Md. | | 25a. REC'D BY REGISTRAR
DA REC 26 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Huns | | | |





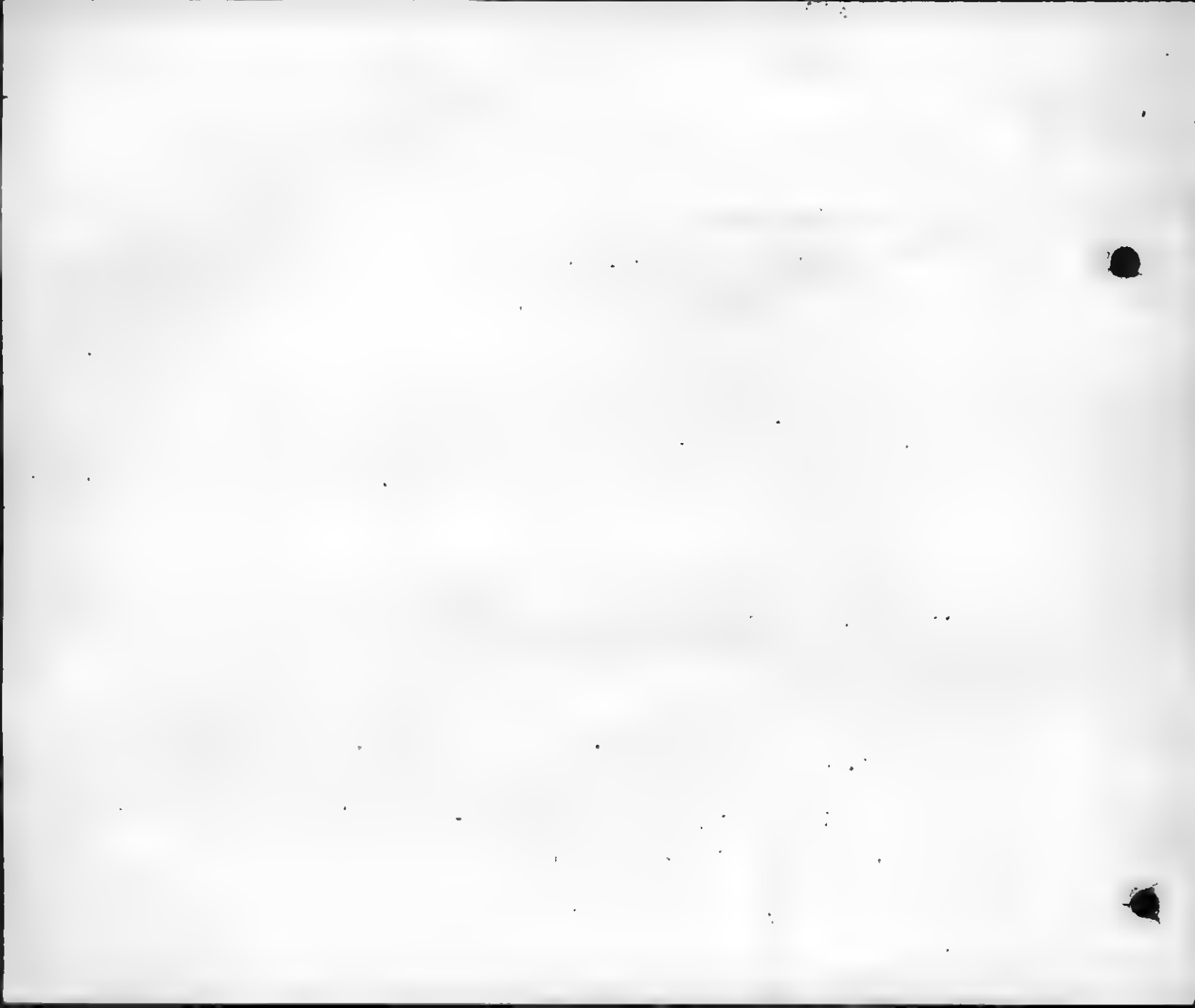
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13847

CERTIFICATE OF DEATH

Reg. Dist. No. 13822

| | | | |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills | |
| c. LENGTH OF STAY IN 1b 5 days | | d. STREET ADDRESS Rd # 4, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Sarah Middle Emiline Last Ruth | | 4. DATE DEATH
Month 12 Day 25 Year 1961 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/22/1881 |
| 9. AGE (In years last birthday) 80 yrs | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | 11. IF UNDER 24 HRS
Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Penna. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Temple | | 14. MOTHER'S MAIDEN NAME Hoopes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --- | | 16. SOCIAL SECURITY NO 213-14-4034 | |
| 17. INFORMANT Roy A. Temple | | Address Elk Mills Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4-22-01 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) several yrs
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH several yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitis and fracture of left humerus on 12/16/61 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 14, 1961 to Dec. 25, 1961 that I last saw the deceased alive on Dec. 25, 1961 and that death occurred at 5:40p M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 12/26/61 | |
| ACTUAL SIGNATURE [Signature] M.D. S. Ralph Andrews, Jr., M.D. | | Elkton, Maryland | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | | Elkton, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12/28/61 | 22c. NAME OF CEMETERY OR CREMATORY Lawn Croft Cemetery | 22d. LOCATION (City, town, or county) (State) Linwood Pa. |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Walter du B... ADDRESS Elkton, Md. | | 24a. REC'D BY REGISTRAR JAN 2 '62 | 24b. REGISTRAR'S SIGNATURE [Signature] |



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13848

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13823

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elton
c. LENGTH OF STAY IN TB 2 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hosp. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md.
b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Shirley R. Streets
First Middle Last | | 4. DATE OF DEATH
December 6, 1961
Month Day Year | |
| 5. SEX Female
6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Dec. 6, 1961
9. AGE (In years last birthday) yrs. Months Days Hours Min 2 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (County & State, or foreign country) Maryland USA
12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Herman W. Streets
14. MOTHER'S MAIDEN NAME Frances M. Clarke | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Herman W. Streets Jr. Elton, Md.
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 750X DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO
(c) An encephalopathy
INTERVAL BETWEEN ONSET AND DEATH 7 months | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from June 1961, to Dec 6, 1961, that (I) (we) last saw the deceased alive on Dec 6, 1961, and that death occurred at 10 PM, from the causes and on the date stated above. | |
| 22a. SIGNATURE
22c. PHYSICIAN'S NAME (Type) Joseph G. Lanzi
22d. ADDRESS 205 West Main Street Elton, Md. | | 22b. DATE SIGNED 12/8/61
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 12/9/61
23c. NAME OF CEMETERY OR CREMATORY Elton Cemetery
23d. LOCATION (City, town or county) Elton, Maryland (State) | | 24. FUNERAL DIRECTOR'S SIGNATURE [Signature]
25a. REC'D BY REGISTRAR DEC 14 61
25b. REGISTRAR'S SIGNATURE | |

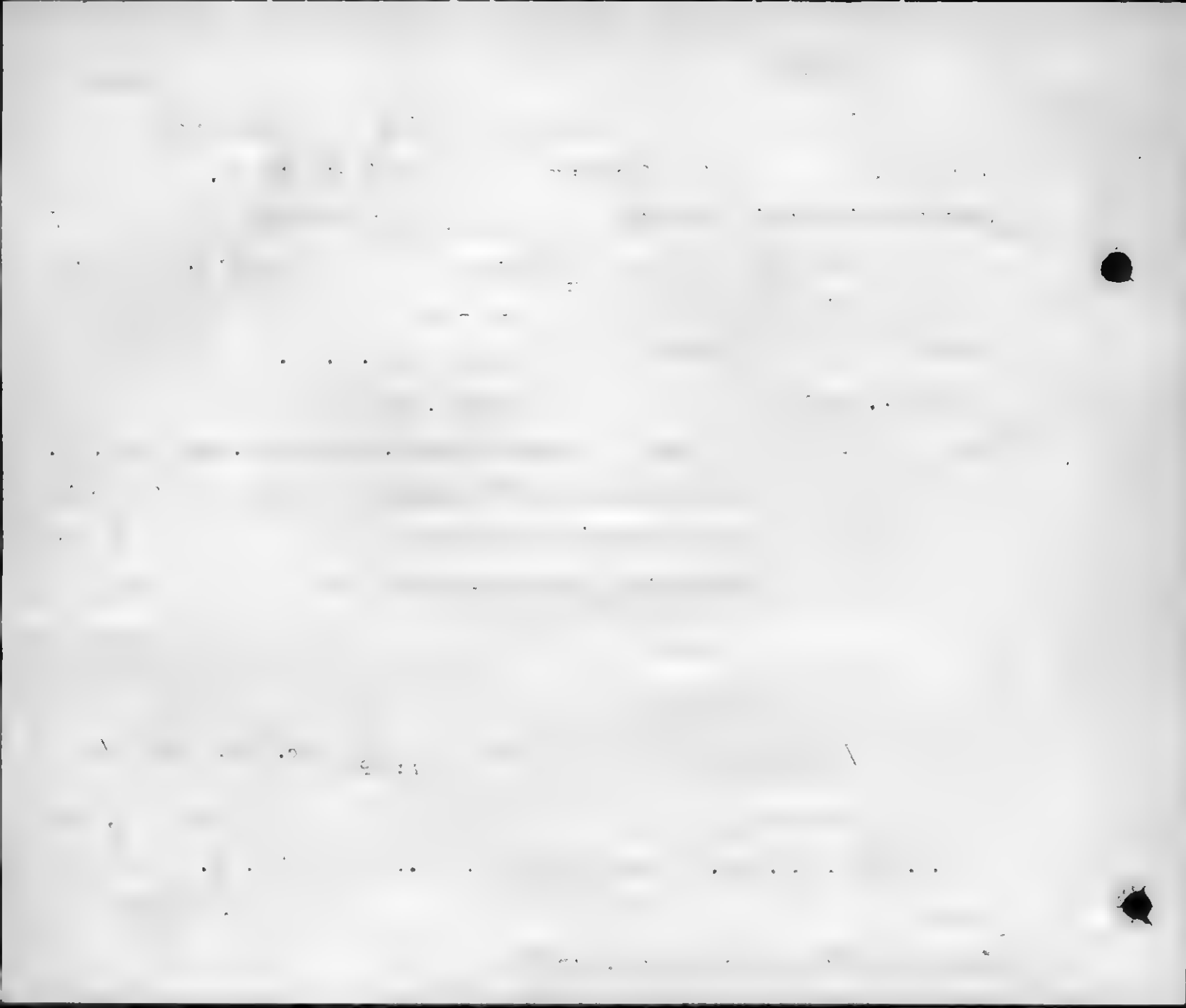


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VR A15, 4)
ISM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13849
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY CECIL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE MARYLAND b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
GLEN BURNIE | |
| c. LENGTH OF STAY IN 1b
34yrs3mos6days | | d. STREET ADDRESS
121 Bonnie View Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First THOMAS Middle JOSEPH Last TRACY | | 4. DATE OF DEATH
Month December Day 2 Year 19 61 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-14-1894 | |
| 9. AGE (In years last birthday)
67 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 11. BIRTHPLACE (County & State, or foreign country)
Lewis County, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
PATRICK J. TRACY | | 14. MOTHER'S MAIDEN NAME
MARY G. SCHMITT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW-1 | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Hospital Records, VA Hospital, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(a) Diffuse Peritonitis w/Subdiaphragmatic Abscess.
(b) Acute perforation of duodenum
(c) Thrombosis of Pancreato-Duodenal artery | | INTERVAL BETWEEN ONSET AND DEATH
3 to 6 days
4 to 7 days
4 to 7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. VA 19
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A.L. MOONEY) attended the deceased from August 25, 19 27 to Dec. 2nd, 1961 and that death occurred at 4:50PM from the causes and on the date stated above. | | 22a. SIGNATURE
A.L. Mooney | |
| 22b. DATE SIGNED
December 3, 1961 | | 22c. PHYSICIAN'S NAME (Type)
A.L. MOONEY, M.D. Asst. Clinical Pathologist, VAH., Perry Point, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/6/1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
BENJAMIN L. SON, Harry DeGrace, Maryland | | 25a. REC'D BY REGISTRAR
DEC 20 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Carlin E. H... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film G302 1-13-61 ink

13825

| | | | |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH 13850
a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fulton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
North East | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Union Hospital | | d. STREET ADDRESS
1600 North East | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
John Troutner | | 4. DATE OF DEATH
Dec 5 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept 25 1878 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Commercial Fishing | |
| 13. FATHER'S NAME
no record | | 14. MOTHER'S MAIDEN NAME
no record | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
219-16-3985 | |
| 17. INFORMANT
Welfare Records Co. | | Address
Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4
DUE TO
Conditions, if any, which gave rise to immediate cause (b) X
(a), stating the underlying cause last. (c)
Pulmonary Embolism
Senility | | INTERVAL BETWEEN ONSET AND DEATH
7 min.
years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebro-Vascular Accident - 4 days. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Dec 1961, to 5 Dec 1961, that (I) (we) last saw the deceased alive on 5 Dec 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wallace O'Brien | | 22b. DATE SIGNED
6 Dec 61 | |
| 22c. PHYSICIAN'S NAME (Type)
Fulton, Md | | 22d. ADDRESS
Fulton, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-7-1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Methodist | | 23d. LOCATION (City, town or county) (State)
North East Cecil Co Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Joseph R Grant | | 25a. REC'D BY REGISTRAR
DATE DEC 8 '61 | |
| ADDRESS
North East Md | | 25b. REGISTRAR'S SIGNATURE
C. L. H. H. H. | |



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14657

1. PLACE OF DEATH 13851
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELKTON
c. LENGTH OF STAY IN lb 1 hr
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE PA b. COUNTY Chester
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Cx Ford
d. STREET ADDRESS RD 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) Sandra Gean Weaver
First Middle Last
4. DATE OF DEATH Dec 12 1961
Month Day Year
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Dec 12 1961
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Weaver 14. MOTHER'S MAIDEN NAME Joan Hall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Robert Weaver, RD 3, Cx Ford, PA.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Congestive heart failure, right heart failure with hypertrophy of right heart, severe pulmonary hypertension, severe atherosclerosis of coronary arteries, and atherosclerosis of aorta.
754.2 DUE TO (b) 2. Double interventricular septal defect
Conditions, if any, which gave rise to immediate cause (c) 3. Double interventricular septal defect
(e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour e.m. p.m. 19 While at work ☐ Not While at work ☐
21. I certify that (I) (this hospital) attended the deceased from 12-12-1961 to 12-12-1961/that (I) (we) last saw the deceased alive on 12-12-1961 and that death occurred at 7:00 PM from the causes and on the date stated above.
22a. SIGNATURE Tillman D. Johnson M.D. 22b. DATE SIGNED 12-14-61
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson 22d. ADDRESS 103 S. Singsley Ave Elkton
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Dec 14/61 23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery 23d. LOCATION (City, town or county) (State) Oxford, Pennsylvania
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks, Elkton, Maryland DATE JAN 11 '62



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MARYLAND STATE DEPARTMENT OF HEALTH

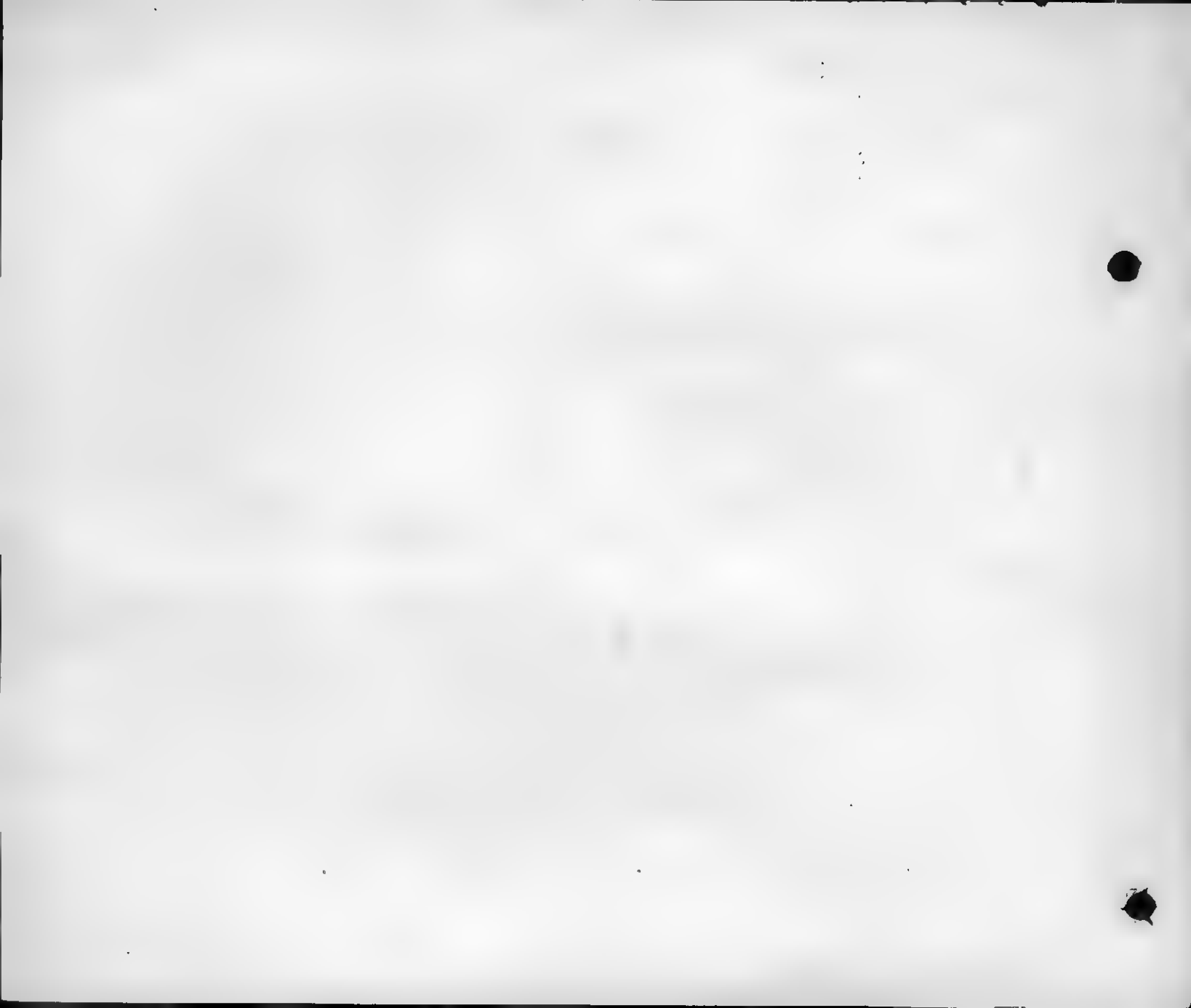
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13852

13826

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>
c. LENGTH OF STAY in lb <u>6 years</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution - residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>No 2 - Weller Boulevard St ELKTON</u>
d. STREET ADDRESS <u>Sugarloaf Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Wisser</u> | | DATE OF DEATH
Month <u>DEC.</u> Day <u>13</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 6 - 1905</u> | |
| 9. AGE (In years last birthday) <u>53</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> | |
| 11. IF UNDER 24 HRS. Hours <u>5</u> Min. <u>3</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman Brick Works</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Refined Clay Brick Works</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Iravosburg, W. Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Charles E. Wisser</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Meyer</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> | |
| 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>CAGREED SMITH</u> Address <u>PITTSBURG, PA.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
26c X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) <u>Heart failure + myocardial</u>
DUE TO
(c) <u>---</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Heart failure about 3 years - myocardial - malefied.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>---</u> a.m. <u>---</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 11, 1961</u> , to <u>Dec. 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 13, 1961</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>H. Arthur Cantwell M.D.</u> | | 22b. DATE SIGNED <u>Dec 16/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>H. Arthur Cantwell</u> | | 22d. ADDRESS <u>North East, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>12/14/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>PITTSBURG</u> | | 23d. LOCATION (City, town or county) (State) <u>PENNA.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FONG RA - Home Location, Md</u> | | 25a. REC'D BY REGISTRAR <u>---</u> 25b. REGISTRAR'S SIGNATURE <u>---</u> | |
| DATE <u>DEC 18 '61</u> | | 25c. REGISTRAR'S SIGNATURE <u>---</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

13853

13827

| | | | | | | | |
|---|--|--|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u>
c. LENGTH OF STAY IN 1b <u>Lifetime</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North East</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u>
d. STREET ADDRESS <u>North East</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Malin</u> First <u>A.</u> Middle <u>Worth</u> Last | | 4. DATE OF DEATH
<u>12</u> Month <u>9</u> Day <u>1961</u> Year | | | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-14-1925</u> | 9. AGE (In years last birthday) <u>36</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>
IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Manager Laundry and Dry Cleaning Estab.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>I. Malin Worth</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Rachel E. Worth</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u> | | 16. SOCIAL SECURITY NO.
<u>216-16-8249</u> | | 17. INFORMANT
<u>I. Malin Worth</u> Address <u>Elkton, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Rupture</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Infart</u>
(c) <u> </u> DUE TO
(e), stating the underlying cause last. <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>instant</u>

<u>1 yr.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> e.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>R.C. Dodson</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
<u>12-10-1961</u>
Rising Sun, Md | | | |
| EXAMINER'S NAME (Type) <u>R.C. Dodson</u> | | Address (Street, city, town, or county) <u> </u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF
<u>12-12-1961</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Methodist</u> | | 22d. LOCATION (City, town, or county) (State)
<u>North East, Cecil</u> | | | |
| 23. FUNERAL DIRECTOR
<u>Joseph R. Grant</u> | | ADDRESS <u>North East, Mr.</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 14 '61</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thane</u> | | |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WYOMING

(M)

ORDER

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|------------------|---|--|--|--|--|---|---|----------------------------------|--|
| 13854 Item 6 Film G504 1/3/62 iwk 12828 | | | | | | | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institutions, residence before admission) | | | | | |
| a. COUNTY CECIL | | | | | | a. STATE MARYLAND | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELKTON | | | | | | b. COUNTY CECIL | | | | | |
| c. LENGTH OF STAY IN 1b 9 Days | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELKTON | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) UNION HOSPITAL | | | | | | d. STREET ADDRESS 1 164 EAST MAIN | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| | | | HARRY S. WYRE | | | 12 26 1961 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| MALE | | White | | | | 9-27-1943 | | 18 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| NONE | | | | - | | | | MARYLAND | | USA | |
| 13. FATHER'S NAME MILFORD WYRE | | | | | | 14. MOTHER'S MAIDEN NAME Ada Rocky | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | | | | 16. SOCIAL SECURITY NO. NONE | | | | | |
| 17. INFORMANT Mrs Ada Wyre 164 E. Main St. Elkton, Md | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right | | | | | | | | | | | |
| 286.5 DUE TO Malnutrition all of life | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked physical and mental retardation | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | 20d. INJURY OCCURRED | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| Hour a.m. p.m. 19 | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | Dec. 17 61 Dec. 26 61 | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 25 61 to 7:20a 19 61 , that (I) (we) last saw the deceased alive on 19 61 , and that death occurred at 19 61 , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Ralph Andrews Jr. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | | | | | | 22d. ADDRESS 233 E. Main St., Elkton, Md. | | | 22b. DATE SIGNED 12/26/61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) | | |
| Burial | | | 12-29-61 | | | Methodist | | | North East Cecil Co Md | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant | | | | | | ADDRESS North East Md | | | 25a. REC'D BY REGISTRAR DEC 29 '61 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |

13854

WARTLAND

Stemodia, white

Wartland

Wartland, white, and white, white

Dec. 19, 1911

Dec. 21, 1911

Wartland, white, and white, white

Wartland, white

Wartland, white

Wartland, white, and white, white